Providence Health Assurance | health share Health Share of Oregon
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthAssurance.com/OHP

Your Right to Access Your Protected Health Information (PHI)

What does my right to access my health information mean?

You have the right to inspect, review or get a copy of your PHI. You also have a right to choose someone else to inspect, review or get a copy of your PHI for you (your personal representative). Your PHI is kept by Providence Health Assurance (PHA) in the designated record set (DRS) per the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A DRS is a group of records about you maintained by or for your plan. It includes certain records used to make decisions about you as a member. The DRS may include records regarding:

- Enrollment
- Claims
- Case management
- Medical management
- Utilization management

What do I need to know to use this right?

- Your access to your records may have legal limits. This could relate to records not accessible under HIPAA.
- You do not have a right to access PHI that is not part of the designated record set.
- You may not be allowed to receive all PHI. For example, you won't receive psychotherapy notes or data compiled for likely use in a civil, criminal, or official action or proceeding.
- Calls are recorded for quality and training purposes only. PHA is not required to transcribe or produce a recorded call.
- PHA will make every effort to produce records in the format you asked for. However, if PHA cannot quickly produce records in the format you want, we'll agree together on an alternate format.
- ***This request is for access to your PHA records. If you need access to your medical/clinical/provider records, you should contact your provider's office and make a separate request.***
- Appeals and Grievances: you may request a copy of the documents collected/created by PHA to respond to an appeal or grievance. It's free. Just call Customer Service at the toll-free number listed on your PHA HealthCare ID card.
- If you want to release sensitive documents of a minor, federal and state laws may prevent PHA from granting your request. You'll need written approval from the minor member to release those documents.

How much will this cost me?

- The records you asked for will be free.

How will I know if my request is processed?

PHA will respond to your request as soon as possible. If we cannot respond within the timeframe, we'll send you a written notice about why it will take longer. Our response will show the date by which we'll fulfill your request. In certain cases, PHA may deny your request. If we deny your request, we'll tell you in writing and let you know if and how you can appeal our decision.

How do I ask for access?

Please complete and sign the form below and return it to Providence Health Assurance at:

Mail:	Fax:	Deliver in Person:
Providence Health Assurance Attn: CBI P.O. Box 4327 Portland, Oregon 97208-4327	503-574-8608	Providence Health Assurance Attn: CBI 3601 SW Murray Boulevard, #10 Beaverton, Oregon, 97005 *Use main entrance on SW Murray Boulevard*

You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free.
Call 800- 898-8174 or TTY:711. We accept relay calls.

Non-discrimination & Communication Assistance | Providence Health Plan

Sincerely,

Providence Health Assurance

Providence Health Plan | Providence Health Assurance

Request to Access Protected Health Information (PHI)

Use this form to request a copy of your PHI in a Designated Record Set that Providence Health Assurance (PHA) or one of its business associates maintains. If you need help completing the form, please contact the PHA Customer Service number listed on your member ID card. Please complete all the fields on this form.

PART A: MEMBER DETAILS		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number** ***(See your member ID card)***	**Group Number** ***(See your member ID card)***
Member Street Address	**City and State**	**ZIP Code**

PART B: HOW TO REQUEST PHI

I request PHI about me in a designated record set held by PHA. By placing an "X" in one of the boxes below, I am indicating who should receive my information. Send my PHI to: (**select only one**)

☐ Me at the address listed above

☐ Electronic or in-person pick-up, as indicated in Part C

☐ Send my PHI to my personal representative listed below:

Name	**Address**	
City and State	**Zip Code**	**Phone Number**

PART C: HOW TO RECEIVE PHI

By placing an "X" in one of the boxes below, I am indicating how I wish to receive/review my information. (Warning: there may be some risk with sending your PHI via unencrypted email or by U.S. mail. It could be read by people who should not have access.) Send my PHI: (**select only one**)

☐ Send paper copies of my records via US certified mail.

☐ Send electronic copy of my records via email. *Note: Information will be sent by secure (encrypted) email unless otherwise specified.*
Email address: _____ Initial if you wish email sent unencrypted: _____

☐ I want to pick up my records in person during regular business hours at the PHA Beaverton office. I understand that I (or my personal representative) will be contacted to arrange for this.

☐ I want to view my records in person. I understand that I (or my personal representative) will be contacted to make arrangements.

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PART D: DETAILS OF PHI REQUEST

I am requesting the PHI contained in the following records. (Please place an "X" next to the items you're requesting).

☐ **Enrollment & Eligibility Information**

Date(s) of Enrollment: _____

Details of Request: _____

☐ **Claims Information, including Pharmacy (Summary of claims paid or denied)**
(This does not include information on claims received but not yet processed – if you would like the status of those claims you may call Customer Service at the toll-free number listed on your HealthCare ID card.)

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

☐ **Case or Medical or Utilization Management Information (Prior Authorization)**

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

☐ **Customer Service Inquiry (CSI)**

Date(s) of Service: _____

Details of Request: _____

☐ **Mental Health (Summary of claims paid or denied)**
If you check this box, please initial mental health below)

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

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I consent to the release of the following sensitive PHI if it's part of my record. This PHI will only be released if I place my initials in the correct space next to it. *I understand that my alcohol/substance abuse records are protected under federal and state privacy laws and regulations. These records cannot be released without my written consent unless the laws and regulations allow it.

(Initial all that apply)

_____	**AIDS/HIV(testing and treatment)**	_____	**Maternity/Pregnancy (Reproductive Health)**
_____	***Alcohol/Drug/Substance Abuse (Diagnosis, treatment, or referral information)**	_____	**Mental Health Data and Records**
_____	**Genetic Information (services or tests)**	_____	**Sexually transmitted illness/ disease (testing and treatment)**

☐ **Other Information**

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

PART E: MEMBER SIGNATURE AND DATE

_____ _____

Member Signature **Date**

- OR -

_____ _____

Member's Legal Representative/Guardian Signature **Date**

Relationship to Member: ☐ **Parent** ☐ **Legal guardian*** ☐ **Holder of Power of Attorney***

***If this form is signed by someone other than the member or parent, please attach legal proof if you are the Legal Guardian or Holder of Power of Attorney.**

- ***Note to parents/legal guardians of minors: State laws may prohibit Providence Health Assurance (PHA) from allowing sensitive information to be released without the minor's written approval. (Both parent and minor must sign.)***