MEMORIAL HERMANN Health Plan

Memorial Hermann Health Plan, Inc.
Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Commercial Health Plan, Inc.

# Request to Access Protected Health Information (PHI)

Use this form to request a copy of your PHI in a Designated Record Set that Memorial Hermann Health Solutions, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Health Plan, Inc. or Memorial Hermann Commercial Health Plan, Inc. (collectively "MHHSI") maintain. If you need assistance completing the form, contact the Customer Service number listed on the back of your Member Identification Card. You must complete all the fields on this form.

**WHEN COMPLETED AND SIGNED PLEASE MAIL TO:** Attn: Customer Service
929 Gessner Road, Suite 1500
Houston, TX 77024
or fax to: 713.338.6550

## Section A: The individual for whom access is being requested. Please complete the following:

Name _____ _____ Group # _____ Subscriber ID # _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Area Code & Telephone Number _____

## Section B: Please place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate specific dates:

| Enrollment Records | From: | To: | Health Records | From: | To: |
|---|---|---|---|---|---|
| ☐ Application/Underwriting/Attending Physician Statement Record | | | ☐ Medical | | |
| | | | ☐ Dental | | |
| ☐ Premium Payment/Billing History (if applicable) | | | ☐ Prescription Drugs | | |
| | | | ☐ Vision | | |
| | | | ☐ Mental Health | | |

This Request CANNOT be used to disclose Psychotherapy Notes.

## Section C: By placing an "X" in the appropriate boxes below please indicate who and in which format/manner you wish to receive/review your information.

**Send my PHI to: (select only one)**

- ☐ Me
- ☐ Designated Third Party: I request that MHHSI send my PHI as specified in Section B, directly above, to the designated third party listed below.

| Name | Address | City | State | ZIP | Phone Number |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Format/Manner: (select only one)**

- ☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted). **Email address:**
- ☐ Send paper copy of information via US Mail.
- ☐ View in person. I understand that I or my designee will be contacted to arrange for this.

## Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that MHHSI provide access to my PHI as specified. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature _____ Date: month/day/year _____

## Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with MHHSI.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ ZIP _____

Personal Representative's Area Code & Telephone Number _____ Personal Representative's E-mail Address (if available) _____