MEMORIAL HERMANN | Health Plan
Health Solutions
Health Insurance Company

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 or Memorial Hermann 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	______	______
☐ Premium Payment/Billing History (if applicable)	______	______	☐ Dental	______	______
			☐ 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) ______________________