Instructions to complete the Highmark Health Options
Member Request for Access to Protected Health Information Form

Section A: Member Information

1. Write the first and last name of the member whose information is being requested.
2. Write the member's identification number.
3. Write the member's address.
4. Write the member's date of birth.
5. Write the member's telephone number.

Section B: Health Information to be disclosed

1. Check the health information that you want disclosed from the list on the form (check all that apply): All records Enrollment; Payment; Claims adjudication; Medical Management; and/or Appeals and Grievances.
2. Check the information that you do NOT want disclosed (check as appropriate): Mental health; Sexually Transmitted Diseases; HIV/AIDS-related Testing and/or Treatment; Alcohol/Drug abuse treatment; and/or Pregnancy/Family Planning.
3. Check the specific dates of service from which you would like the information to be disclosed.
4. Check who should receive the information:
   a. You at the address associated with your file.
   b. You at a different address that you need to list below.
   c. A designated person at an address that you need to list below.

Section C: Signature

1. This form must be signed and dated by the member whose information is to be released.
2. If the member is unable to sign this form, a personal representative with legal authority on file with Highmark Health Options may sign and date the form. If a personal representative is signing the form on the member's behalf:
   a. Write the personal representative's relationship to the member.
   b. Write the personal representative's telephone number.
   c. Write the personal representative's address.

Section D: Personal Representatives

If you are completing this form on behalf of a Highmark Health Options member please indicate in this section the legal authority that gives you this right (i.e. Personal Representative form, Healthcare Power of Attorney, legal guardianship, etc.).

If you have not already done so, you will be required to complete an Authorization to Use and Disclose Form and submit it to Highmark Health Options. If the form is not on file when we receive this form, the request will be denied. The form can be obtained and returned in the same manner as the Access Request Form.

Member Request for Access to Protected Health Information

Section A: Member Information (Please Print)	
Member Name:	Member ID:
Address:	
Date of Birth:	Telephone:

Section B: Health Information to be disclosed:

By completing and submitting this form, I request to review protected health information (PHI) about me in a "designated record set" held by Highmark Health Options in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). For purposes of this form, a "designated record set" is a group of records maintained by or for Highmark Health Options including enrollment, payment, claims and health plan case or medical management record systems; or records used by or for Highmark Health Options to make decisions about members.

☐ Select the health information you would like disclosed (check all that apply):

- ☐ All records
- ☐ Enrollment
- ☐ Payment
- ☐ Claims
- ☐ Medical Management
- ☐ Appeals and Grievances

☐ Disclose my information as above, **BUT DO NOT** include information related to (check all that apply):

- ☐ Mental health
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS-related Testing and/or Treatment
- ☐ Alcohol/Drug abuse treatment
- ☐ Pregnancy/Family Planning
- ☐ Other (please specify): ____

List specific dates of service: Start date: ____/____/_____ End date: ____/____/_____

☐ I request that a copy of PHI about myself be mailed to me at the address above.
☐ I request that a copy of PHI about myself be mailed to me at the address listed below:
☐ I request that a copy of PHI about myself be mailed to _______________ at the following address:
(designated person)

Address:

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

Section C: Signature

I understand that Highmark Health Options has 10 days to respond to this request, starting from the day we receive it.

I understand that if Highmark Health Options grants this request, in whole or in part, it will inform me of the acceptance of this request and provide a copy of the records requested.

I understand that Highmark Health Options has the right to deny the request, in whole or in part, and will provide me with a written denial.

I understand that this request does not apply to certain health information, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and (4) other health information not subject to the right to access information under HIPAA.

I understand that this request for access to my protected health information is only applicable to the information maintained by Highmark Health Options. If I would like access to my protected health information maintained by any health care provider, a separate request must be submitted to that provider.

I understand that if my request for access to PHI is denied, I may have the right to request a reconsideration of the denial decision. I must submit my request for reconsideration in writing to:

Highmark Health Options WV
Attn: Enrollee Services
614 Market St.
Parkersburg, WV 26101

I understand that any form returned to Highmark Health Options incomplete will be returned to me for completion and my access request will not be implemented until all the information is received complete and processed.

I understand that if I change health care benefits coverage, or leave Highmark Health Options and later return as a member, I will need to resubmit this request.

Signature: ____________________________________ Date: ____________________

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (i.e. general power of attorney) that verify the signer's authority to act for the member.

Section D: If you are a Personal Representative filling out this form for a Highmark Health Options member, please write that relationship below and the legal reason that gives you this right (i.e. Power of Attorney, guardian, etc.). If you have not done so, you will be required to fill out an Authorization to Use and Disclose Form and send it to Highmark Health Options. You can get the form and return it in the same way as the Access Request Form.

If you are not the member, print your name:	Relationship to member:
Legal form on file:	Telephone number:
Address:	

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association,
an association of independent Blue Cross Blue Shield Plans.

HIGHMARK
HEALTH OPTIONS

Discrimination Is Against the Law

Highmark Health Options complies with applicable Federal civil rights laws and regulations and does not discriminate on the basis of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options does not exclude people or treat them differently because of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Help in Your Language

Highmark Health Options provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do kat idantifikasyon w lan (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：(TTY: 711）。

注：英語を話す場合は、無料の言語支援サービスを利用できます。 あなたのIDカードの裏面（： 711 TTY）の番号を呼び出します。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ તો, તમારા માટે ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 카드 뒷면의 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: Se parla italiano, per Lei sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero presente sul retro della Sua carta di identificazione (TTY: 711).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tawagan ang numero sa likod ng iyong card (TTY: 711).

कृपया ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निशुल्क उपलब्ध हैं। अपने पहचान कार्ड के पीछे दिए गए नंबर पर कॉल करें (TTY: 711)।

توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ کے پیچھے درج نمبروں پر ہمیں کال کریں (ٹی ٹی وائی: 711)۔

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (الهاتف النصي: 711).

గమనిక: మీరు తెలుగు మాట్లాడే వారైతే, భాషా సహాయక సేవలు, ఖర్చు లేకుండా, మీరు లభిస్తున్నాయి. మీ ఐడి కార్డుకు (TTY: 711) వెనుక వైపు ఉన్న నంబర్‌కి ఫోన్ చేయండి.

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