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REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Access request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

GEHA Health Plan (includes Connection Vision Plan)

GEHA Connection Dental Federal Plan (includes Connection Vision Plan)

CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)

CONNECTION Vision Plan only

You have the right to inspect and/or obtain a copy of your protected health information in a designated record set for as long as the information is maintained in the set, unless law prohibits access to that information. If access is denied, in whole or in part, a timely, written denial will be provided advising the basis for the denial, including if the denial is for unreviewable or reviewable grounds. If access is denied on reviewable grounds, a statement of your review rights and how you may exercise such review rights will be included, along with a description of how you may file a complaint.

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED.

I request access to my protected health record as follows:

Subscriber/Member Information:

Subscriber Name: ______________________________

Address: ______________________________

Subscriber ID Number: ____________________ **Telephone Number:** ____________________

Patient Name: ______________________________ **Date of Birth:**____________________

Dates of Service from: ______________ **to** ______________

Description of Information Desired ______________________________

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Method:

I would like a **paper copy of the information requested.**
I understand that fees may apply.

I would like an **electronic copy of the information requested**.

Specify electronic form and format desired______________________________
I understand that fees may apply.
Note: If GEHA is unable to provide the electronic form and format requested, you will be contacted to determine an alternate acceptable one.

I would like to **view the information requested at GEHA**. I understand I will be contacted by GEHA to arrange a date and time to come to your office.

I would like a **summary of the requested information rather than the actual record set**.
If I choose to request a summary of my health information, I will be contacted by GEHA with an estimate of the cost of the summary. I am not obligated to pay for the summary unless I agree to this cost. If I do not agree to the cost, I may withdraw my request for the summary and ask for the actual records

I request the information be sent directly to the person and address designated below.

Mail to Name: ______________________________

Mail to Address: ______________________________

GEHA and GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc. (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com) must act on a request for access no later than 30 days after the receipt of the request. If unable to take action during that time, GEHA may take up to 30 additional days (60 days total) and will send you a written statement of the reasons for the delay and the date when a response will be sent within the first 30 days. If all or part of your request for access is denied, you will be notified in writing of the denial.

Date: ______________

Patient or Legal Representative Signature: ______________________________

Relationship to patient: ______________________________
(i.e. parent, legal guardian, medical power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

GEHA
ATTN: Access Request
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283