Request for Access to Protected Health Information

I, ________________________ (name), _________________ Social Security Number, hereby request a copy of my health information from the San Francisco Electrical Workers Health and Welfare Plan (Health Plan) for the following dates: __________________________________.
I request the health information contained in the following records (please check one or more):

☐ enrollment

☐ premium/contribution payment

☐ case or medical management

☐ claims, billing and EOB information relating to the following service or claim: (specify date of service and/or medical condition) _____________________________________
____

☐ customer service

☐ all of the above

☐ other (please specify) ____

I understand that I may access my health information through any of the following methods (please check the desired method):

☐ I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time, during normal business hours, to come to the Health Plan office by calling the Privacy Official at (415) 263-3670. I understand I will be charged a per page copying fee of $________.

☐ I prefer to have the requested information copied and mailed to me at the following address: ____
____.
I understand I will be charged a copying and postage fee of $_________.

☐ I prefer to receive a written summary of the requested information, instead of the complete records, for the fee of $_________.

____ _____/_____/_____
Signature of Requestor Date

If signed by personal representative:
Name of personal representative: ___________________________

Relationship to participant or nature of authority:____________________

____ _____/_____/_____
Signature of Personal Representative Date

Submit Form to: Privacy Official, 720 Market St., Suite 700, San Francisco, CA 94102