INDIVIDUAL REQUEST TO INSPECT HEALTH INFORMATION

THIS FORM WILL ALLOW ME, AS A CITY OF HOUSTON SELF-INSURED MEDICAL GROUP HEALTH PLANS CUSTOMER, TO REQUEST ACCESS TO PROTECTED HEALTH INFORMATION (PHI) ABOUT ME THAT THE CITY OF HOUSTON SELF-INSURED GROUP HEALTH PLANS MAINTAIN, AND THAT WAS CREATED OR RECEIVED BY THE PLANS DURING MY COVERAGE

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items).

Name of Customer: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Employee ID No.: _____

Group or Account No. on ID Card: _____

Subscriber Name (if different from Customer): _____

Subscriber Relationship to Customer: _____

I request to review health information held about me in the City of Houston Self-Insured Medical Group Health Plans' "designated record set," in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A "designated record set" includes information such as medical records; billing records; enrollment, payment, claims adjudication and health plan case or medical management record systems; or records used to make decisions about individuals.

I understand that the Plans' administrator has 30 days to respond to this request, and that if someone else holds the information or it is off-site, the response time is 60 days.

I request that the information be provided in the following format: (circle one) Paper / Electronic

Optional: I agree that the group health plan may provide a summary of the health information instead of allowing me to review the information.

I agree to pay any fees for copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I agree to a summary).

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 litigation; and (4) other information not subject to the right to access information under HIPAA.

Signature _____ Date _____

Printed Name _____

Please Return This Completed Form To: Privacy Officer, City of Houston Self-Insured Medical Group Health Plans, Human Resources Department, 611 Walker, 4th Floor, Houston, Texas 77002; Email: PrivacyOfficer@houstontx.gov; FAX: 832.393.7208.