Part I: Request for access to inspect/copy personal health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set" maintained by the Health and Welfare plan ("Plan"). This may include medical and billing records maintained for a health care provider; enrollment, payment, claim adjudication, and case or medical management record systems; or a group of records the Plan uses to make decisions about individuals. You may request an electronic copy of your health information if it is maintained in an electronic format and the form and format you request is reasonably accessible by the Plan. You may also request that a copy of your health information be sent to another entity or person, as long as that request is clear, conspicuous and specific.

You do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although you may request a review of the denial in certain circumstances.

The Plan may provide you with a summary or explanation of the information in your health plan records instead of access to or copies of your records, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

Form received by:	Date:
1. Employee name:	
1a. Employee date of birth:	1b. Health plan ID number:
2. Name of person whose records are requested:	2a. Relationship to employee: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify relationship):
3. Your name:	3a. Relationship to person in Line 2:
4. Mailing address for records:	4a. City, State, ZIP code:

Section A: Requested personal records

Please identify the personal health information in your health plan records you would like to access and the time period to which the information relates:

Part I: Request for access to inspect/copy personal health information

Section B: Access methods

Please choose the method(s) you would like to use for accessing the personal health information described in Section A:

☐ I would like to review the records requested in Section A in person. I will arrange a mutually agreeable time to do so by contacting [*contact person*].

☐ I would like to copy the records requested in Section A in person. I will arrange a mutually agreeable time to do so by contacting [*contact person*]. I understand that I will be charged, and I agree to pay copying costs of $__ per page.

☐ I would like to have copies of the records requested in Section A sent to me at the address in Line 4. I understand that I will be charged, and I agree to pay copying costs of $ ___ per page, plus postage.

☐ I would like to have electronic copies of any records requested in Section A that are kept electronically sent to me at the address in Line 4. I understand that I will be charged, and I agree to pay the associated cost.

☐ I would like to have copies of the records requested in Section A sent to the following person or entity _____ at the address in Line 4. I understand that I will be charged, and I agree to pay the associated cost.

☐ I would like to have electronic copies of the records requested in Section A that are kept electronically sent to the following person or entity _____ at the address in Line 4. I understand that I will be charged, and I agree to pay the associated cost.

☐ I would like to have the information summarized (instead of receiving the entire record) and sent to me at the address in Line 4. I understand that I will be charged for the summary, and I agree to pay the cost of preparing the summary, any copying at $____ per page and postage.

Signature: **Date:**

Return completed form to:

Benefits Services Manager

350 Spelman Lane

Atlanta, GA 30314

404 270-5092

Part II: Response to request for access to personal health plan records

After reviewing your request for access to inspect and/or copy personal health plan records, *Benefits Services Manager* has made the following determination [*check one*]:

☐ **Request approved** (see Section A below).

☐ **Request partially approved and partially denied** (see Sections A and B or C below).

☐ **Request denied with no right of review** (see Section B below).

☐ **Request denied with right of review** (see Section C below).

Section A: Request approved without a fee

Your request for access to personal health plan records is granted _____ (*in full/in part*). _____ (*All/Some*), of the health information requested is available to you for inspection, copying or both. If you asked to review the records in person, contact Benefits Services Manager at 404 270-5092 to do so. If you asked to have a copy or a summary of the records sent to you, the document is attached.

Section B: Request denied with no right of review

Your request for access to personal health plan records is denied [*in full / in part*] for the following reason(s) [*check all that apply*]:

☐ The information is psychotherapy notes.

☐ The information is for civil, criminal, or administrative proceedings.

☐ The information is created for research, and you agreed to forgo access while the research is in progress.

☐ The information is subject to the Privacy Act (5 USC § 522(a)), and access may be denied under that law.

☐ The information was obtained from someone other than a health care provider under a promise of confidentiality, and access would reveal the source.

☐ The Plan does not have the information, and the Benefits Services Manager does not know who maintains it.

☐ The Plan does not maintain the information. For access, contact CIGNA, which maintains the information.

Section C: Request denied with a right of review

Your request for access to personal health plan records has been denied [*in full / in part*] because a licensed health care professional has determined that access is reasonably likely to endanger someone.

You have a right to ask the Plan to have the denial reviewed by another licensed health care professional. If you wish to ask the Plan to review this denial, send a written at Spelman College. For more information, contact Benefits Services Manager, at 404 270-5092.

Plan representative name: **Determination date:**