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Request for Accessing/Inspecting/ Copying Health Information

Member Identification

Member Name			
Date of Birth	/ /	Member ID Number	
Member Home Phone Number	( ) -	Member Work Phone Number	( ) -
Address			Apt/Suite Number
City		State	Zip Code

Request to Access/Inspect/Copy

I hereby request to ☐ Access/Inspect
☐ Copy
my health information in the following designated record set(s) for the period of time from

_____ to _____ :

☐ Medical Records
☐ Financial Records
☐ Categories of records that are used, in whole or in part, to make decisions about Members
☐ Employee health records maintained by an Company's Employee Health Service
☐ Enrollment, payment, claims adjudication information maintained by a health plan
☐ Other Company designated record sets: _____

I understand there is specific health information to which this Company may deny access, without my having an opportunity for review, as follows:

- Psychotherapy Notes
- Information compiled for civil, criminal, or administrative action or proceeding
- Health information subject to the Clinical Laboratory Improvement Amendments of 1988
- Information created or obtained in ongoing research that includes treatment if this was a condition of participation in the research; denial of access without an opportunity of review will be removed at the conclusion of the research
- Records that are subject to the Privacy Act, 5U.S.C. 522a
- Health information obtained under a promise of confidentiality

I further understand there may be circumstances when a licensed health care professional may deny my request for access to my health information; and that I am allowed to request a review by another licensed health care professional.

Signature	Title (If Personal Representative)	Date

Request Determination on Reverse Side

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This Section for Company Use Only

Review of Request

Determination: ☐ **REQUEST APPROVED**

Company Responsibilities:
- ☐ Determination of method for Member access
- ☐ Notice to Member of approved access
- ☐ Offer Member summary of information
- ☐ Notify Member of requirements for copies of health information

Determination: ☐ **REQUEST NEEDS FURTHER REVIEW**

Designated Staff ..... Date .....

Review of Request by Licensed Health Care Professional

Determination: ☐ **REQUEST APPROVED**

Company Responsibilities:
- ☐ Determination of method for Member access
- ☐ Notice to Member of approved access
- ☐ Offer Member summary of information
- ☐ Notify Member of requirements for copies of health information

Determination: ☐ **REQUEST DENIED**

Reason for denial:
- ☐ Reference made to another person could endanger that person
- ☐ Access could endanger life or physical safety of Member or other(s)
- ☐ Access requested by personal representative and access could cause substantial harm to Member or other(s)
- ☐ Other .....

Company Responsibilities:
- ☐ Written Notice to Member of basis for denial
- ☐ Provide Member with Opportunity to Request Review by licensed healthcare professional

Licensed Health Care Professional ..... Date .....

Request Denied-Second Review

Determination: ☐ **REQUEST APPROVED**

Company Responsibilities:
- ☐ Determination of method for Member access
- ☐ Notice to Member of approved access
- ☐ Offer Member summary of information
- ☐ Notify Member of requirements for copies of health information

Determination: ☐ **REQUEST DENIED**

Reason for denial:
- ☐ Reference made to another person could endanger that person
- ☐ Access could endanger life or physical safety of Member or other(s)
- ☐ Access requested by personal representative and access could cause substantial harm to Member or other(s)
- ☐ Other .....

Company Responsibilities:
- ☐ Written Notice to Member of basis for denial
- ☐ Provide Member with contact information for US DHHS Secretary

Licensed Health Care Professional ..... Date .....

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How To Submit This Form to Carolina Complete Health

You may submit this form in two ways:

By Mail

Please mail the request to:

Carolina Complete Health
Attn: Privacy Office
1701 North Graham Street
Suite 101
Charlotte, NC 28206

By Email

You may email the completed PDF as an Email attachment to:

CCH_Compliance@carolinacompletehealth.com

Support

If you need help in submitting this document, you may reach out to Member Services at 1-833-552-3876 (TTY 711), Monday-Saturday 7 AM - 6 PM EST.