REQUEST FOR ACCESS TO DESIGNATED PROTECTED HEALTH INFORMATION RECORDS

Use this form when you want to see your own health information records that are kept by Neighborhood.

INSTRUCTIONS

Section A: **Fill in the member name, address, phone number and Neighborhood ID number.**

Section B: **If you are a member's Personal Representative, please add your name here and attach the proper document** (for example, a signed Power of Attorney).

Section C: **Select the Neighborhood records you would like to receive.** You have the right to see the record of your protected health information including enrollment, claims payments, grievance and appeals, and case management records (Neighborhood policies #000051 and # 000655). These records may not include information such as copies of psychotherapy notes, information we have collected for legal use and certain other records.

You can either choose to see all of your records or you can ask for specific records. Please include the dates of these records.

Section D: **Choose how you would like to receive these records (only select one option). You can have paper copies mailed to you or electronic files sent by email.** Keep in mind, after records are sent to you, they are no longer protected under privacy laws by Neighborhood. It is up to you to keep them safe and private. We have the right to charge a small fee to copy your records for you. We will contact you if we cannot give you your records in the format you have asked for.

Section E: **You MUST sign this document.**

Please return this form to:

Neighborhood Health Plan of Rhode Island
Attn: Compliance Department
910 Douglas Pike
Smithfield, RI 02917

If you need help with this form please contact Neighborhood Member Services at 1-800-963-1001 (TTY 711).

Neighborhood Health Plan of Rhode Island's INTEGRITY for Duals (HMO D-SNP) and Dual CONNECT (HMO D-SNP) are health plans that contract with Medicare and the Rhode Island Medicaid Program. Enrollment in Neighborhood Health Plan of Rhode Island's INTEGRITY for Duals or Dual CONNECT plan depends on contract renewal.

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Neighborhood Health Plan OF RHODE ISLAND™

REQUEST FOR ACCESS TO DESIGNATED PROTECTED HEALTH INFORMATION RECORDS

SECTION A: MEMBER INFORMATION

Please fill out:

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	MEMBER ID#

SECTION B: PERSONAL REPRESENTATIVE

*Only complete this section if you are not the member. Please print your name below and then check the box that describes your relationship to the member. **Please attach proof of your relationship to the member (ex. power of attorney, guardianship, etc.).**

Print name of personal representative: _____

- ☐ **Legal guardian**: Attach guardianship documentation, which must have a court's stamp and signature.
- ☐ **Power of attorney**: Attach power of attorney (must include authorization of the release of health care information)
- ☐ **Executor**: Attach letter of appointment of executorship, which must have a court's stamp and signature.

SECTION C: DATE OF RECORDS

Choose one:

☐ A summary of all records during the following time:

FROM _____ (MONTH) _____ (YEAR) ***TO*** _____ (MONTH) _____ (YEAR)

☐ Specific records: _____

_____

_____

SECTION D: TYPE OF RECORDS YOU WANT TO RECEIVE (check one)

☐ Paper copies mailed to:

_____ NAME

_____ STREET ADDRESS

_____ CITY, STATE, ZIP

☐ Electronic copies sent by secure email:

_____ EMAIL ADDRESS

SECTION E: SIGNATURE

_____ *MEMBER or PERSONAL REPRESENTATIVE SIGNATURE*

_____ *DATE*