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 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.** Please keep in mind: once records are sent to you, they are no longer protected under privacy laws by Neighborhood. It is up to you to keep these documents safe and confidential.

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

Neighborhood Health Plan of Rhode Island complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-459-6019 (TTY 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-459-6019 (TTY 711).

If you need help with this form please call Neighborhood Member Services at 1-800-459-6019 (TTY 711).

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#

You have the right to see the Neighborhood record of your protected health information including eligibility, enrollment, payment, claims, appeals and case/medical management records. These records may not include information such as copies of psychotherapy notes, information we have collected for legal use and certain other records.

SECTION B: PERSONAL REPRESENTATIVE

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 ____________ ____________ ***TO*** ____________ ____________
MONTH YEAR MONTH YEAR

☐ Specific records: ______________________________

____

____

SECTION D: TYPE OF RECORDS (check one)

☐ Paper copies mailed to: ______________________
NAME
____
STREET ADDRESS
____
CITY, STATE, ZIP

☐ Electronic copies *(choose one)*

☐ PDF file sent by email: ***OR*** ☐ CD-ROM sent by US mail to address above

____
NAME
____
EMAIL ADDRESS

Neighborhood Health Plan of Rhode Island will contact you if we cannot give you your records in the format you have asked for. We reserve the right to charge a small fee to copy your records for you.

SECTION E: SIGNATURE

______________________ ______________________
MEMBER/PERSONAL REPRESENTATIVE SIGNATURE *DATE*