8/1/18

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ACCESS REQUEST FORM

About You

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Member Name: _____ **Date of Birth:** _____

Please place a check mark in front of each plan you want this Access request to be applied:

- ☐ GEHA Health Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* Plan
- ☐ CONNECTION Vision Plan

Information To Be Released

Description of Protected Health Information Desired _____

_____

_____

Dates of Service from: _____ **to** _____

Format:

- ☐ Paper Copy
- ☐ Summary of Requested Information (a fee may be charged)
- ☐ Electronic Copy
- ☐ Inspection at GEHA (an appointment will be scheduled)

Information to be released to: ☐ Self ☐ Other (Please fill in contact information below)

Mail to Name: _____

Mail to Address: _____

- I understand that my request will be processed within 30 days. GEHA may take up to 30 additional days to fulfill the request, but will inform me within 30 days of receipt of the request of the need for an extension.
- I understand that, under HIPAA, I have the right to inspect and/or obtain a copy of my protected health information maintained in a designated record set, unless otherwise prohibited by law.
- I understand that this request may be denied in whole or in part. If so, except as otherwise permitted under applicable law, I have the right to request a review of this decision and understand that GEHA will communicate these rights in the case it denies my request.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Access Request
GEHA
P.O. Box 21542
Eagan MN 55121
FAX: 816.257.3283