HealthPlan OF SAN MATEO

801 GATEWAY BLVD., SUITE 100, SOUTH SAN FRANCISCO, CA 94080
TEL 650-616-0050 **FAX 650-829-2050** **TTY 800-735-2929**

Request For Access to Protected Health Information (PHI)

Member's Name:		Member's DOB:	
Telephone Number:		Member ID No:	
Name of Requestor		Relationship to Member:	
Requestor's Telephone Number		Date of Request:	

I am requesting access to the following dates of information:

From:		To:	

The Health Plan of San Mateo keeps protected health information (PHI) and related documents for six (6) years from the date of creation.

I am requesting access to the following type(s) of information (Check all that apply and describe under each box checked the specific information you would like to request. Include dates of service and/or provider names, if applicable. Use additional sheets of paper as needed):

❑ Eligibility and enrollment history

Dates: _____
_____
_____

❑ Treatment Authorization Requests (TARs) (Please specify TAR Numbers, if known.)
Dates: _____
_____
_____

❑ Claims Information
Dates: _____
_____
_____

❑ Referral Authorization Information
Dates: _____
_____
_____

❑ Records on billing issues
Dates: _____
_____
_____

❑ Information related to a grievance
Dates: _____
_____
_____

❑ Other, please specify:

_____
_____
_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

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If access to records is approved, please mail the information to me at the address listed below (please complete):

_____

_____

_____

I understand that if HPSM approves my request for access to health information, HPSM will act on my request for health information within 30 days from receipt of the request. By signing this request, I agree initially to accept a summary of the information that I have requested. I understand that more information may be available to me, if the summary does not meet my needs.

Signature of Member/ Legal Representative	Legal Representative's Authority (Relationship to Member)	Date

Print Name of Member/Legal Representative
Whose Signature Appears Above

Mail your completed form to the following address:

Health Plan of San Mateo
Attention: Compliance
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

You can also fax the completed form to 650-829-2050 or email a scanned copy to Compliance@hpsm.org.

If you have any questions or would like help in completing this form, please call the Health Plan of San Mateo at **650-616-0050**, Monday through Friday 8:00 AM–5:00 PM.