univera HEALTHCARE

DESIGNATED RECORD SET ACCESS/AMENDMENT REQUEST OR ACCOUNTING OF DISCLOSURES

You have the right to inspect and obtain a copy or request that we amend your protected health information (PHI) in a designated record set (DRS). A DRS is information we maintain and use to make decisions about your health care coverage. We may decline your request if the information is not part of the DRS, we did not create the information, we believe the information is complete and accurate, or the information is psychotherapy notes, compiled in anticipation of, or for use in, any civil, criminal or administrative proceeding, or not subject to disclosure to under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. §263a). You also have the right to an accounting of disclosures which is an account of instances when your PHI was disclosed by our health plan. An accounting of disclosure is not required where the disclosure was made: i) to carry out our payment, healthcare operations activities, ii) with your explicit authorization, iii) directly to you or your personal representative, iv) for national security or intelligence purposes, or v) to certain law enforcement agencies. To request access, amendment or accounting related to your PHI, please complete Part A as well as Part B, C, or D, as applicable.

PLEASE PRINT – READ FORM CAREFULLY AS NOT ALL FIELDS WILL BE APPLICABLE TO YOUR REQUEST

PART A: INDIVIDUAL WHOSE INFORMATION IS THE SUBJECT OF THIS REQUEST

LAST NAME		FIRST NAME	MI
CURRENT ADDRESS		CITY	STATE/ZIP CODE
HOME PHONE #	CELL PHONE # *(optional)*	BIRTH DATE MM / DD / YYYY	ID # *(located on membership ID card)*

PART B: REQUEST FOR DESIGNATED RECORD SET

Check one: ☐ **All Records** ☐ **Specific Records** *(describe below)*

- **Do you agree to receive PHI in a reader-friendly, descriptive summary format? ☐ Yes ☐ No**
- **Date range for records being requested:** MM / DD / YYYY to MM / DD / YYYY
- **If you are seeking "Specific Records," please describe the records you wish to receive:**

☐ Membership record ☐ Claim data ☐ Clinical data ☐ Other *(please specify)*_____

PART C: REQUEST FOR AMENDMENT OF DESIGNATED RECORD SET

Specific Record and Requested Change: _____

Reason for amendment: _____

PART D: REQUEST FOR ACCOUNTING OF PHI DISCLOSURES

☐ Disclosures of PHI from MM / DD / YYYY to MM / DD / YYYY ☐ Disclosures related to: _____

(Note: The accounting period will be up to six (6) years prior to the request date.)

PART E: REQUEST FOR SPECIAL PROCESSING

Our standard response will be by postal mail to the individual at the address named above within thirty (30) days, or sixty (60) days if we notify you that additional time is necessary to access the information. If your request is outside our standard response, please indicate it in this section.

☐ Send information to a third party *(information disclosed to a third party is no longer protected by HIPAA Privacy Regulations and may be subject to redisclosure):*

Name:_____Address:_____City/State/Zip: _____

If you would like any of the below condition(s) included in the response to the third party, please initial next to the condition(s).

____ Genetic testing ____ HIV/AIDs ____ Substance use disorder

____ Sexually transmitted diseases ____ Abortion ____ Mental health *(excluding psychotherapy notes)*

☐ Send in an electronic format (USB/password protected) ☐ Secure Email – email address:_____

☐ Other _____

PART F: YOUR RIGHTS (PLEASE READ AND SIGN)

With the exception of one free disclosure of PHI accounting each 12 months, I understand that the Health Plan reserves the right to impose a reasonable fee for the cost of copying, supplies, labor and postage. If a fee will be imposed, I will be notified in advance of fulfilling my request. **I affirm that I am the individual who is the subject of the information requested on this form and/or that I am authorized to perform the action requested.**

Signature:_____**Date:** _____

If this request is from a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:_____**Description of Authority:** _____

We must have documentation related to your authority to act on behalf of the individual, e.g. power of attorney

INCOMPLETE FORMS WILL NOT BE PROCESSED. BE SURE TO RETAIN A COPY FOR YOUR RECORDS. COMPLETE AND RETURN TO:

Univera Healthcare – Corporate Privacy Office | 333 Butternut Drive | Syracuse, NY 13214-1803