



## Request for Copies of Protected Health Information

**Please Note: There is a fee required for all requests.**

Last name appearing on records same as below, or: \_\_\_\_\_

Mr.  Mrs.  Ms.  Miss

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Address: (Street/Apt. No./P.O. Box/R.R. No.) \_\_\_\_\_

City/Town/State/Zip Code: \_\_\_\_\_

Telephone Number (Day): (    ) \_\_\_\_\_

Telephone Number (Evening): (    ) \_\_\_\_\_

Detailed description of requested records, personal information or personal information to be corrected. (If you are requesting access to or correction of your personal information, please identify the personal information bank or record containing the personal information, if known.)

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**Note:** If you are requesting a correction of personal information, please indicate the desired correction and, if appropriate, attach any supporting documentation. You will be notified if the correction is not made and you may require that a statement of disagreement be attached to your personal information.

**Preferred method of access to records:**

Examine Original

Receive Copy

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Internal Use Only**

Date Received: \_\_\_\_\_ Request Number: \_\_\_\_\_

Comments:

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*Note: Personal information contained on this form is collected pursuant to the HIPAA Privacy Rule and will be used for the purpose of responding to your request. Questions about this request should be directed to the Privacy and Security Office at AmeriHealth Administrators.*