

## Request for Access to Protected Health Information

I, \_\_\_\_\_ (name), \_\_\_\_\_ (participant identification number), hereby request a copy of my health information from the AFTRA Health Fund ("Fund") for the following dates: \_\_\_\_\_. I request the health information contained in the following records (please check one or more):

- enrollment
- premium/contribution payment
- case or medical management
- claims, billing and EOB information relating to the following service or claim: (specify date of service and/or medical condition) \_\_\_\_\_
- customer service
- all of the above
- other (please specify) \_\_\_\_\_

I understand that I may access my health information through any of the following methods (please check the desired method):

- I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to the Fund by calling the Privacy Officer. I understand I will be charged a per page copying fee of \$\_\_\_\_\_.

Signature of Participant/Eligible Dependent \_\_\_\_\_

Date \_\_\_\_\_

If signed by personal representative:

Name of personal representative: \_\_\_\_\_

Relationship to participant or nature of authority: \_\_\_\_\_

Signature of Personal Representative \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date