FirstCare HEALTH PLANS

Request to Access Protected Health Information (PHI)

By law an individual has the right to inspect and obtain a copy of his or her PHI in the Designated Records Set(s) that FirstCare Health Plans or its Business Associates maintain, as well as to request this information. **If you need assistance completing the form, please contact the Customer Service number listed on the back of your Member Identification Card.**

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:

FirstCare Health Plans
12940 N HWY 183
Austin, Texas 78750

NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Section A: The individual for whom access is being requested. Please complete the following:

Name ______ Date of Birth ______ Group # ______ Identification\Subscriber # ______

Address ______ City ______ State ______ ZIP ______

Area Code & Telephone Number ______

Section B: Please place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate specific dates:

Enrollment Records	From:	To:	Health Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record			☐ Medical		
Premium Payment/Billing History (if applicable)			Dental		
			Prescription Drugs		
			Vision		
			Mental Health		

This Request CANNOT be used to disclose Psychotherapy Notes.

Section C: By placing an "X" in the appropriate boxes below please indicate who and in which format/manner you wish to receive/review your information.

Send my PHI to: (select only one)

☐ Me

☐ Designated Third Party: I request that FirstCare Health Plans send my PHI as specified in Section B above directly to the designated third party listed below.

Name	Address	City	State	ZIP	Phone Number

Format/Manner: (select only one)

☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified. **Email address:**

☐ Send paper copy of information via US Mail.

☐ View in person. I understand that I or my designee will be contacted to arrange for this.

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that FirstCare Health Plans provide access to my PHI as specified. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature ______ Date: month/day/year ______

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with FirstCare Health Plans.

Personal Representative's Name ______ Relationship to Individual ______

Personal Representative's Address ______ City ______ State ______ ZIP ______

Personal Representative's Area Code & Telephone Number ______ Personal Representative's E-mail address (if available) ______