

REQUEST FOR COPIES OF MEMBER RECORDS



Complete this form to request a copy of a member's health plan records.

Please print legibly. Incomplete forms won't be processed. All sections must be completed unless otherwise specified.

PART A: INFORMATION of HMSA MEMBER whose records are being requested			
Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone No.	Cellphone No.	
HMSA Subscriber No(s). (from your HMSA membership card)			Birthdate (mm/dd/yyyy)
PART B: REQUEST TYPE (please check all that apply)			
I am requesting copies of the following types of records:			
☐ Claim summary reports (contains payment information)	☐ Case management/Appeals	☐ Other (please specify):	
OR			
☐ Individual claim forms (NO payment information)	☐ Enrollment	☒ All of the above	
PART C: RECORD DATES			
Please specify the period of time for which you are requesting copies of records. (For example, records dating from "02/01/2021 through 05/01/2021").			
FROM _____ THROUGH _____ MM/DD/YYYY MM/DD/YYYY			
PART D: SEND MY RECORDS TO A THIRD PARTY			
You have the right to request that your records be sent to a third party. The person or organization you identify below may not be subject to federal health information privacy laws. If this is the case, they may further release your confidential member information and federal health information laws may no longer protect it.			
Send my records to:			
Last Name Clifford	First Name Pat		MI
Organization Name Legal-Ease Digital Imaging LLC			
Address 2496 Meadowcroft Dr	City Burton	State MI	ZIP Code 48519
Email pat.legalease@gmail.com	Phone No. 855-534-4003	Fax No. 810-547-4030	

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PART E: RECORDS FORMAT

Please indicate the format you'd like the records in:

- ☒ Electronic (your files will be encrypted) ☐ Paper ☐ On-site record inspection

PART F: DELIVERY METHOD

- ☒ **Send via certified mail.** HMSA will mail your records to the address in your HMSA account.
- ☐ **Pick up at an HMSA location.** Select an HMSA location below. You'll be notified when your records are ready.
- ☐ **On-site record inspection.** Select an HMSA location below. You'll be notified when your records are ready for inspection.

HMSA location:

- ☐ HMSA Center - Honolulu ☐ HMSA Center - Hilo ☐ Kauai Office
- ☐ HMSA Center - Pearl City ☐ HMSA Center - Kahului

PART G: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

I have the right to obtain a copy of my protected health information in a HIPAA-designated record set that HMSA or its business associates maintain. I am not, however, entitled to obtain a copy of any psychotherapy notes HMSA may have; any information HMSA may have compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding; any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a); records that are not part of my designated record set, and certain other records. I'm entitled to receive a copy of this signed form if I request one.

PART H: SIGNATURE

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form.

Member Signature: _____ **Date:** _____

*If signed by other than the member, parent of minor child, or legal representative, please provide the following information for identity verification so that we may update any future requests from you. Provide a copy of verification of your legal rights (e.g., child's birth certificate, power of attorney document) to make this request.

Last Name	First Name	MI	
Address	City	State	ZIP Code
Home Phone No.	Cellphone No.		
Email	Relationship to Member		
Last Four digits of Driver's License No. or State ID No.	Birthdate (mm/dd/yyyy)		

- ☐ I have included a copy of verification of my legal rights (e.g., power of attorney, court document, etc.) to make this request. I understand that if I previously submitted such a document, I don't need to resubmit it.

Please complete, sign, and submit this form to:

HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860. Fax: (808) 952-7580