



Request for Access Form

This form lets you inspect or obtain a copy of your PHI that Meridian maintains.

Meridian cannot give you access to or copies of:

- Psychotherapy notes we may have
- Info we may have used for civil, criminal or administrative action or proceeding
- Info not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988
- Other info as defined in the Privacy Rule (CRF 164)

You will receive a written response to your request within 30 days of our receipt of this form or a notice that we elected to extend our time to respond by an additional 30 days.

SECTION 1: YOUR INFO

Name:		DOB:
Member ID#:		Phone:
Address:	City:	State/Zip:

SECTION 2: INFO YOU ARE REQUESTING

Tell us what info you need:

Date range for the info you are asking for: _____
From: (mm/dd/yyyy) To: (mm/dd/yyyy)

SECTION 3: REQUEST REASON (CHOOSE ONE)

☐ To help with my health care	☐ For my own records	☒ For a lawsuit, legal action, court case, settlement, etc.
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Other:

SECTION 4: WHERE TO SEND YOUR PHI (CHOOSE ONE)

Who is this being sent to? Legal-Ease Digital Imaging LLC 2496 Meadowcroft Dr Burton, MI 48519

How should it be sent:

- ☐ Fax to:
- ☒ By email: pat.legalease@gmail.com
- ☐ In person at a location decided by Meridian (must have an appointment)
- ☐ Other electronic formation (e.g. CD)
- ☐ By mail to the following address:

PHI02 MI

Address: _____

City: _____

State/Zip: _____

SECTION 5: SIGN AND DATE

Who is signing? ☐ Member listed above ☐ Parent of minor member listed above ☐ Someone other than Member

Signature: _____

Date: _____

Name (printed): _____

Description of authority to act on behalf of the member (e.g., durable power of attorney, court order, parent of minor child, etc.): _____

* You must attach the legal records shown above that name you as the representative of this member. There will be delays in this request if you do not give us this info

SECTION 6: RETURN THE FORM

Send us a copy of this form by choosing one of the following:

1. Fax this form to 313-324-9075
2. Email this form to privacy.mi@mhplan.com
3. Send this form in the enclosed envelope to the address below. No stamp is needed.

Privacy Officer
Meridian Health Plan
1 Campus Martius, Suite 700
Detroit, MI 48226

Authorization to Use and Disclose Health Information

Notice to Member:

- ✓ Completing this form will allow Meridian to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- ✓ You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Meridian will not change if you do not sign this form.
- ✓ Right to cancel (revoke): This authorization/consent form is subject to revocation at any time except to the extent that the Meridian or other lawful holder of your health information that is permitted to share it has already acted in reliance on it. If you want to cancel this Authorization Form, fill out the Revocation Form on the last page and mail it to the address at the bottom of the page.
- ✓ Meridian cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- ✓ Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- ✓ Fill in all the information on this form. When finished, mail it to the address at the bottom.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____

I give Meridian permission to use my health information for the purpose identified or to share my health information with the person or group named below. The purpose of the authorization is:

- ☐ to allow MeridianHealth to help me with my benefits and services, or
- ☒ to permit MeridianHealth to use or share my health information for Litigation.

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): Pat Clifford - Legal-Ease Digital Imaging, LLC

Address: _____

City: _____ State: MI Zip: 48501 Phone: _____

I AUTHORIZE MERIDIAN TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

- ☒ **All of my health information INCLUDING:** genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records
(please specify any substance use disorder information that may be disclosed:) _____; **OR**
(continued on next page)

mimeridian.com

☐ **All of my health information EXCEPT (check all boxes that apply):**

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Mental health data and records (but not psychotherapy notes)

- ☐ Drug and alcohol data and records
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

Authorization End Date: _____ (date the authorization ends unless cancelled)

Member Signature: _____ **Date:** _____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: Meridian, 1 Campus Martius, Suite 700, Detroit, MI 48226 313-324-3700

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) TO RECEIVE INFORMATION

NOTE: If you are consenting to disclose any substance use disorder records to an recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name (person or group): _____

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