ACCESS REQUEST – A one-time request for records

Purpose: This form is used to make a one-time request to inspect and/or obtain copies of your protected health information maintained by your insurer as allowed by law.

Please type or print neatly; we will not process incomplete or illegible forms.

Section A: RELEASE THE RECORDS OF: (Please complete each field)

Last Name: ______________________ **First Name:** __________________________ **MI:** _____

Street Address: ____ **Apt #:** __________

City: ___________________________________ **State:** __________ **Zip:** ____________

Phone: (home) ___________________ **(work)** _______________________

Member ID#: _____________________________ **Date of Birth:** ____/____/_____

Section B: INFORMATION TO BE RELEASED:

In the event the records you requested were not received in paper form, a summary and/or an explanation of the records will be mailed to you unless otherwise indicated.

Please specify the records you wish to inspect or obtain copies of:

____

____

____

____

____

____

NOTE: *Copies of your Explanations of Benefits (EOB) and the diagnosis and procedures codes related to the care listed on the EOB are available from Customer Service. To receive this information please contact Customer Service at the telephone number located on your membership card.*

Section C: RELEASE INFORMATION TO A THIRD PARTY:

Complete this section **ONLY** if you want us to mail your records to someone else.

At your request we will release the records you requested to a third party. Please list the name and address of the person to whom you want us to release the above requested records.

Please mail the records to:

Name of individual or organization: ____

Address: ____

City, State, Zip: ____

1. I understand that I am authorizing NCAS to the release of the records listed in Section B to the individual or organization listed in Section C.
2. I understand that this is voluntary and is initiated at my request.
3. I understand that the information released to the individual or organization listed in Section C may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
4. I understand that the completion of this section is not required. My health plan will not condition payment, enrollment, or eligibility of benefits on my completing Section C of this request.
5. I understand that I may revoke this request at any time by sending a written notification to the Privacy Office at the address listed below and this revocation will be effective upon receipt by my health plan. However, I further understand that this revocation will not be effective for information that my health plan has already used or disclosed, relying on the completion of Section C of this request.

Section D: SIGNATURE AND DATE:

Signature: ____ Date: ___________________

Print Name: ____

Must be the original signature of any person 18 years of age or older whose records have been requested.

If this request is made by a personal representative on behalf of the individual please attach a complete copy of the personal representative form or legal document indicating your legal authority to sign this form.

Please mail or fax the completed form to:

Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692

Please keep a copy of this request for your records.