# Request for Access to Health Information

As a participant of UPCAP MI Choice Waiver Program, you have the right to access your Personal Health Information(PHI). If you want to access your health information you must complete this form and return it to UPCAP Services, c/o Mary Ross, P.O. Box 606, Escanaba, MI 49829.

If we deny your request, we will let you know in writing with an explanation of why we are denying it. You have the right to submit a written disagreement to our denial. We will put your statement and requested access in to your record. If we continue to disagree with your access request, we may put a written rebuttal to your disagreement into your record. If this occurs, we will let you know in writing and send you a copy of our rebuttal.

| INDIVIDUAL'S INFORMATION | |
|---|---|
| Name: | Request Date: |
| Contact Phone Number(s): | Birthdate: |
| Current Address (No., Street, P.O. Box, City, State, Zip): | |

## REQUESTED INFORMATION

1.Specify the Personal Health Information (PHI) being requested:

2. Time Period for Requested Information: From:_____ To: _____

3. Purpose of Request (Please describe the reason for requesting access to PHI):

4. Access Preferences-Preferred method of receiving information (check one):
☐In-person ☐Paper copy ☐Electronic (email):_____
_____

5. Preferred language: _____

***ACKNOWLEDGEMENT-Please sign and date:***

Name _____ Signature _____ Date _____

**If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof of your relationship to the participant (e.g. power of attorney, legal guardian).**

Name _____ Signature _____ Date _____

☐ **Personal Representative** ☐ **Legal Guardian** ☐ **Power of Attorney** ☐ **Executor** ☐ **Other:** _____

## *This Section for Company Use Only*

**Access has been: ☐ Accepted ☐ Denied (if denied, check the reason for denial):**

- ☐ **PHI (Protected Health Information) was not created by this organization**
- ☐ **PHI is not part of the participant's designated record set**
- ☐ **Federal/State law forbids making corrections to this PHI**
- ☐ **PHI is accurate and complete**

**Comments:**

**Access request has been reviewed by:**

| _____ | _____ | _____ |
|---|---|---|
| **Date** | **Please print name** | **Signature** |
| _____ | _____ | _____ |
| **Date** | **Please print name** | **Signature** |

**Notification was sent to the participant:** _____
**Date**

*Send a copy of completed form to individual. Send original to Support Corrdinator to place in Participant's chart.*

*Date copy sent:* _____ *Copy sent by (print name):* _____