



Request for Access to Health Information

As a participant of UPCAP's 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): <input type="checkbox"/> In-person <input type="checkbox"/> Paper copy <input type="checkbox"/> 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
<input type="checkbox"/> Personal Representative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Executor <input type="checkbox"/> Other: _____		

This Section for Company Use Only

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

- Psychotherapy Notes
- Information compiled for legal proceedings
- Access could endanger life or safety
- Third Party Information

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): _____