Collective Health

Revised 9/25

REQUEST TO ACCESS HEALTH RECORDS

Collective Health is contracted by your employer-sponsored health plan ("Health Plan") to administer your Health Plan's benefits. Use this form to request a copy of your protected health information (PHI) in a designated record set that your Health Plan, Collective Health, and/or their business associates maintain. You must complete all the fields on this form.

PLEASE UPLOAD THE COMPLETED FORM AS A NEW MESSAGE IN YOUR MY COLLECTIVE PORTAL OR MAIL TO US AT: COLLECTIVE HEALTH, ATTN: PRIVACY OFFICE, 1557 W. INNOVATION WAY, SUITE 300, LEHI, UT 84043.

Section A: The individual for whom records are being requested. Please complete the following:

_____ _____ _____

Name **Subscriber ID #** **Date of Birth**

_____ _____ _____ _____

Address **City** **State** **ZIP**

_____ _____

Telephone Number **E-mail Address (if available)**

Section B: Place an "X" in the box next to the records you wish to obtain a copy of and indicate specific dates. (Sign your initials to authorize the release of sensitive services, if applicable.):

Enrollment Records: From: To:

- ☐ **Application/Underwriting/Attending Physician Statement Record** _____ _____
- ☐ **Premium Payment/Billing History** _____ _____

Health Records: From: To:

- ☐ **Medical** _____ _____
- ☐ **Dental** _____ _____
- ☐ **Prescription Drugs** _____ _____
- ☐ **Vision** _____ _____
- ☐ **Mental Health** _____ _____
- ☐ **Sensitive Services** ***Member Initials Required:*** _____ _____ _____

This request cannot be used to disclose Psychotherapy Notes or phone records that are not part of the designated record set.

Section C: Who would you like us to send your records to? (select only one)

- ☐ **To the Member and Address listed in Section A (skip to Section D), OR**
- ☐ **Designated Third Party (complete the following):**

_____ _____

Name **Address**

_____ _____ _____ _____

City **State** **ZIP** **E-mail Address (if applicable)**

Section D: Place an "X" in the appropriate box below to indicate the format/manner you wish to receive your information.

Format/Manner: (select only one)

- ☐ **Send an electronic copy. Note: Information will be sent to the email address provided above via secured (encrypted) email unless otherwise specified. If unencrypted email is requested, you acknowledge this method is not secure and you understand and accept the risks associated with it.**
- ☐ **Send a paper copy via US Mail to the mailing address provided above.**

Section E: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that my Health Plan, Collective Health, and their business associates provide access to my PHI as specified. I understand that I can sign on behalf of a child as their parent only if they are under the age of 18, unless there is proof of other legal authority.

_____ _____

Signature* **Date: month/day/year**

**If you are signing as a power of attorney, legal guardian, executor, or administrator, attach a copy of the legal documents granting authority.*