HIPAA Request Form

I hereby request the following with respect to my protected health information ("PHI"):
(Complete only those sections relevant to your request(s))

☐ **Please share my PHI with using the following alternative communication method:**

- □ E-mail Address: _____
- □ Fax Number: _____
- □ Regular mail Address: _____
  _____
- □ Other _____
  _____

I understand that I will be responsible for the payment of any reasonable fees connected with my request.

I request that the following communications of information be subject to this request:

_____

_____

□ I certify that the disclosure of all or part of the information described above could endanger me.

□ **Please DO NOT use or disclose my PHI to my relatives, friends, or other persons who are identified by me and are involved in my care:**

Description of information to be restricted:

_____

_____

Description of how use or disclosure should be restricted:

_____

_____

Please do not disclose any PHI to the following individuals or entities:

_____

_____

I understand that the Plan is not required to agree to the restrictions listed above that I have requested.

□ ***Check only if applicable***

My PHI would otherwise be disclosed for purposes of the Plan's payment or health care operations (not for treatment purposes), and I certify that the PHI pertains solely to a health care item or service for which the healthcare provider has been paid out of pocket in full.

□ **Please provide me with an accounting of all of the disclosures of my PHI that have been made by Populus Group Welfare Benefits Plan.**

List the dates for which you are requesting an accounting (NOTE: may not be more than six years prior to the date of your request, or three years prior to the date of a request for an accounting of disclosures from an electronic health record):

From _____/_____/_____ To _____/_____/_____

If you wish to limit the accounting to those disclosures made to a specific person or entity, please identify that person or entity here. If this section is left blank, an accounting of **all** disclosures made during the time period listed above will be provided:

_____

I understand that Populus Group Welfare Benefits Plan is not required to provide an accounting of disclosures of PHI made (a) to carry out treatment, payment or health care operations (unless I am requesting an accounting of disclosures of my PHI from an electronic health record used or maintained by the Plan); (b) to me; (c) incident to a use or disclosure otherwise permitted or required by HIPAA; (d) pursuant to an individual authorization; (e) to certain persons involved in my care or payment for that care; (f) to notify certain persons of my location, general condition or death; or (g) as part of a "limited data set" (as defined in HIPAA), which largely relates to research purposes.

□ **Please provide me with a copy of PHI about myself that is maintained in the designated record set.**

□ I request that the information be provided in the following format

(circle one): Paper Electronic Format

I understand that if the format requested is not readily producible, except to the extent Populus Group Welfare Benefits Plan is required to provide the information in an electronic format, Populus Group Welfare Benefits Plan will provide a readable hard copy form or such other form or format as agreed to by Populus Group Welfare Benefits Plan and myself.

I do_____do not_____agree that Populus Group Welfare Benefits Plan may provide a summary of the health information instead of allowing me to review the information.

□ **Please send a copy of my PHI to the following entity or person, at the following address:**

_____

_____

□ **I wish for my PHI held by Populus Group Welfare Benefits Plan to be amended as follows:**

Describe PHI to be amended:

_____

_____

Describe amendment requested:

_____

_____

State reason for requested amendment:

_____

_____

Other parties who need the corrected information:

_____

_____

I understand that if the protected health information was not created by Populus Group Welfare Benefits Plan, Populus Group Welfare Benefits Plan is not required to honor my request. I also understand that if the information is not available for my inspection, is not part of the Populus Group's designated record set, or is already accurate and complete, I cannot amend the information.

Signature of Individual or Individual's Representative

_____ _____

Signature of Individual or representative Date

If an individual's representative signs this authorization, the following additional information must be provided:

_____

Name of personal representative (please print)

_____

Relationship to the individual, including authority for status as representative.

Return this completed form to:

Populus Group Welfare Benefits Plan 3001 West Big Beaver Road, Suite 400 Troy, Michigan 48084-3105
HIPAAPrivacyOfficer@populusgroup.com