

Your rights regarding your health information with Grand Valley Health Plan

This form is used for a member's request: (please check ✓ all that apply)

<input type="checkbox"/>	To amend protected health information or records
<input type="checkbox"/>	To restrict our use or disclosure of protected health information for treatment, payment or health care operations or to persons involved in the patient's care or payment for that care
<input type="checkbox"/>	That we use alternative means or an alternative location when communicating about protected health information that we maintain
<input type="checkbox"/>	To document a patient's request for an accounting of disclosures of protected health information that we maintain
<input type="checkbox"/>	To inspect and/or obtain copies of his or her own protected health information

Required information, please complete:

Member's full name _____ Date of Birth: _____

Home address: _____
(Include city, state & zip)

Social Security #: _____ Daytime Telephone Number: _____

Please read the following about your rights regarding your health information:

- **Right To Inspect And Copy.** You have the right to inspect and copy your health information that we maintain. Usually this includes your medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in very limited circumstances. If we deny your request to access your health information, we will explain why the request was denied and whether you have the right to a further review of the denial.
- **Right To Request Amendments.** If you feel that your health information is incorrect or incomplete, you may ask us to correct the information. You must include with your request an explanation of how and why your health information needs to be corrected. We may deny your request for correction in certain limited circumstances. If we agree to your request for correction, we will take reasonable steps to inform others of the correction.
- **Right To Request An Accounting Of Disclosures.** You have the right to request an accounting of disclosures. This is a list of certain disclosures of your health information that

we have made to third parties. This is limited to disclosures made on or after April 14, 2003. If you request this accounting more than once in any 12 month period, we may charge you for the cost of responding to these additional requests. Your request should tell us how you want the list (e.g., on paper, via e-mail, or on a disk).

- Right To Request Additional Restrictions. You have the right to request a restriction on how we use or disclose your health information to third parties for your medical treatment, payment of your medical claims, or management of our health care operations. You also have the right to request a limitation on how we disclose your health information to those involved in your care or the payment for your care, such as a family member or friend. For instance, you can request that we not disclose information to your spouse or children concerning a sensitive surgical procedure or a disease you have suffered. *Please note that under federal law, we are not required to agree to your request.*
 - Right To Request Confidential Communications. We communicate to you information about your health care treatment and payment. If you feel that our communicating with you may endanger you, you may request that we communicate with you using a reasonable alternative means or location. For example, you can ask that we contact you only at work, by e-mail, or by mail at a specified address (such as a P.O. box, rather than your home mailing address). We will accommodate all reasonable requests.
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**To amend protected health information or records**

Specifically state the records you wish to amend and what the amendments are you wish to make (attach additional sheets if necessary):

Specifically state your reasons for the requested amendment:

Required: signature and date:

Signature of member or parent or legal guardian if minor

Date

Printed name of member or parent or legal guardian if minor

**To restrict our use or disclosure of protected health information for treatment, payment or health care operations or to persons involved in the patient's care or payment for that care**

Specifically state the protected health information that wish to be handled in a restricted manner and the restriction(s) you want us to apply (attach additional sheets if necessary):

Specifically state your reasons for the requested restriction(s):

Required: signature and date:

Signature of member or parent or legal guardian if minor

Date

Printed name of member or parent or legal guardian if minor

That we use alternative means or an alternative location when communicating about protected health information that we maintain

Specifically provide the full information on the alternative means you want us to use (i.e. another address, phone number, name etc.):

Specifically state your reasons for the requested alternate communication means:

Required: signature and date:

Signature of member or parent or legal guardian if minor

Date

Printed name of member or parent or legal guardian if minor

To document a patient's request for an accounting of disclosures of protected health information that we maintain

Specifically state the date range for the accounting of disclosures you are requesting.

Specifically state your reasons for the requested accounting of disclosures:

Required: signature and date:

Signature of member or parent or legal guardian if minor

Date

Printed name of member or parent or legal guardian if minor



To inspect and/or obtain copies of his or her own protected health information

Specifically state the specific records you require as well as a date range for the records:

Specifically state your reasons for the requested restriction(s) and the manner in which you prefer to receive access to your designated record set (i.e. by mail or pick up in person at your health center):

Required: signature and date:

Signature of member or parent or legal guardian if minor

Date

Printed name of member or parent or legal guardian if minor
