COMMUNITY HEALTH NETWORK of Washington™ | Cascade Select

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Community Health Network of Washington
Request Access to Protected Health Information (PHI)

Use this form to request a copy of your protected health information (PHI) that is kept by Community Health Network of Washington (CHPW) in the designated record set. The designated record set includes records used to make decisions about you as a member. It might also include records about enrollment, claims, plan case management, medical management, or pharmacy information.

There may be legal limits on your access to records. For example, a licensed health care professional can limit your access if they think that giving you the information would endanger your safety or the safety of others. We may charge you a reasonable fee. When a fee applies, we will tell you how much it will be so you can decide if you want to change or cancel your request.

1. **Member Name:** _____ **Date of Birth:** _____

Member ID Number: _____ **Date of Request:** _____

Member Address: _____

Member email: _____

Member Phone: _____ **Member Fax:** _____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. I request to review my PHI in a "designated record set" held by CHPW in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

2A: check only <u>one</u> box to tell CHPW how you want to review your requested records outlined below:

☐ I want to review my PHI during regular business hours at the CHPW office.

☐ I want a copy of my PHI to be emailed/mailed to:

_____

2B: check only <u>one</u> box below to tell CHPW whether you want a summary of your PHI:

☐ Yes, CHPW may give me a summary of my PHI.

☐ No, CHPW may **not** give me a summary of my PHI.

3. I request the PHI contained in the following records.

☐ **Enrollment and Eligibility Information:**

Date(s) of enrollment: _____

Details of request: _____

☐ **Claims information:**

Date(s) of service: _____

Provider(s): _____

Details of request: _____

☐ **Case or Medical Management Information:**

Date(s) of service: _____

Provider(s): _____

Details of request: _____

☐ **Grievance and Appeals Information:**

Date(s) of service: _____

Provider(s): _____

Details of request: _____

☐ **Other (please describe):**

_____

4. I understand that a copy of my PHI will be provided to me within 30 days of the date of this request, unless CHPW extends the timeframe for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive a copy of the information. I understand that in certain cases CHPW may deny my request and will notify me in writing if my request is denied and will inform me how I can appeal the denial decision. I understand that communication via mail or email may not be secure.

_____	_____	_____
Printed Name	**Phone**	**Date**

_____
Signature

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the member: _____

4. Send the completed, signed request to:

Community Health Network of Washington
Attn: Compliance Officer
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 652-7050
Email: compliance.officer@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHNW's Customer Service department at the following:

Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8am to 5pm.

If you hare hearing or speech impaired, please call TTY 711 (toll-free).

The notice is also available online at: https://www.cascadeselect.org/member-center/member-rights/