

Protected Health Information (PHI) Access Authorization

BY MEMBER FOR THIRD PARTY ACCESS OR RESTRICTION OR REVOCATION

To submit the PHI Request, please email to: phi@evergreenmd.org or fax to: **[844] 412-7884**.

Note: This request is limited to information the health plan has on file as of the date of this request.

THE PHI ACCESS IS FOR THE FOLLOWING:

Third Party Access to PHI

Request to Restrict or Revoke Third Party Access to PHI

Date of request:	MONTH	DAY	YEAR	Member Name:		
Member Date of Birth:	MONTH	DAY	YEAR	Member Evergreen Health ID Number:		
Street Address		City		State	Zip Code	
Email Address			Phone Number			
Access Period:	____ / ____ / ____		To:	____ / ____ / ____		
	day	month	year	day	month	year

Check all that apply:

I authorize the disclosure and/or use of the following information:

- Any information related to a specific claim (specify date of service or type of treatment): _____
- My entire medical record on file with the health plan
- My enrollment, eligibility and premium payments
- Other (describe information in detail): _____

Method of disclosure: Please release my records/information via: (Check all that apply)

- Mail In person pick-up by patient OR authorized representative Secured email

Who will be receiving information about the individual? This information may be disclosed to:

Name (a person, a class of persons like "family members residing with me", or an organization)	Phone No.
Street Address:	City, State and Zip Code:

Request for release/intended use: _____

Individual or entity RESTRICTING/REVOKING access from: ____ / ____ / ____ to: ____ / ____ / ____

day month year day month year

Documents to be RESTRICTED: All

I understand that this authorization will expire at the end of my plan year unless a shorter time frame is requested.

PLEASE SIGN BELOW

Signature of Member		MONTH	DAY	YEAR
<i>If minor:</i> Signature of Parent or Legal Guardian		MONTH	DAY	YEAR

REQUEST TO ACCESS PHI [45 CFR 164.508]

Members may request another individual have access to the member's PHI. Access may be granted for a specific reason, time period, or indefinitely. The member has the right to revoke access at any time. Requests to revoke access must be in writing. A description of the purpose for the requested use or disclosure must be included in the release writing. "At the request of the individual" is sufficient when the member initiates the authorization and does not provide a statement of purpose.

REQUEST TO RESTRICT ACCESS [45 CFR 164.522]

Members have the right to request the restriction of use or disclosure of their PHI. Evergreen Health must agree to restrict access if the disclosure is for carrying out payment or health care operations and is not required by law and PHI pertains solely to health care item or service that has been paid in full. Restrictions may include:

- Uses and disclosures to carry out treatment, payment or health care operations
- Disclosures to family members, other relative, or other person identified by member of PHI directly relevant to such person's involvement with the member's health care or payment
- Notification to another of member's location, general condition, or death
- Use by health care providers when the member cannot agree to or object to use or disclosure because of incapacity or emergency circumstances

Evergreen Health has the right to deny a request for restriction of access. If Evergreen Health agrees to the restriction, they must comply with the restriction except in cases of treating a medical emergency. Agreed upon restrictions are not effective when the use or disclosure of PHI is required by law. The member may restrict access for a specific period of time or indefinitely. The restriction of access may be terminated or changed at any time. Terminations of access must be communicated in writing or orally with the oral agreement documented.

