SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

501 Shatto Place, 5th Floor . Los Angeles, CA 90020 . (800) 595-PIPE (CA only) . (213) 385-6161 . Fax: (213) 383-0725

REQUEST FOR PROTECTED HEALTH INFORMATION

PURPOSE OF THIS FORM

In order for Southern California Pipe Trades Health and Welfare Fund ("Fund") to provide access to Protected Health Information ("PHI"), this Request for Protected Health Information form must be completed and returned to the Fund. Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies the person who is the subject of the information or provides a reasonable basis for identifying that person.

You, or a person acting on your behalf, have a right to see or copy your PHI for as long as the Fund maintains your PHI in a "designated record set." A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you.

You may use this form if you are requesting your own PHI; if you are requesting someone else's PHI and the Fund has an Authorization Form permitting you to access that person's PHI; or if you are the Personal Representative of the individual whose PHI you are requesting.

______________________________ ______________________________

Name of Individual Whose PHI is Being Requested (Please print) **Social Security Number**

Please indicate whether you want to inspect PHI at the Fund Office and/or whether you want the Fund Office to mail you copies of PHI by marking all that apply:

☐ I want to schedule a time (during regular business hours) to inspect PHI at the Fund Office.

1. I would like to view my PHI for the following dates, ______________ to ________________.
2. The Fund office hours are from 8:00 a.m. to 4:00 p.m., Monday thru Friday. What date and time would you like to inspect your records?

______________________ ______________________

Date Time

☐ I want the Fund to send me copies of PHI : *(see page 2)*

You may be charged a reasonable cost for these copies.

The charges are as follows:

- .10 cents per copy
- $15.00 per hour for research beyond the current year
- Postage

☐ I am requesting **ALL** my claims records from the Fund Office and I understand there will be a charge.

☐ I am requesting my claims records for the dates of_________to _________ and I understand there will be a charge.

Please mail my records to:

Name: ___________________________

Address: ___________________________

City, State and Zip___________________________

___________________________ ___________________________

Name of Authorized Person Requesting PHI (Please print)

Signature of Authorized Person
(or Signature of Personal Representative*)

**If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.*

Date_________________

The Fund will usually act on your request within 30 days of receiving this form. If the Fund needs additional time to take action, you will be notified.

If you have any questions please call the Fund office at the above number and ask to speak to the Privacy Officer.