HIPAA ACCESS REQUEST

Purpose: This form is for use by the TRICARE beneficiary or the beneficiary's authorized representative to request access to inspect and/or to obtain a copy of the beneficiary's protected health information contained in the designated record set maintained by TriWest or the designated record set maintained for TriWest by one of its business associates.

SECTION A: INDIVIDUAL REQUESTING ACCESS

Name:		
Address:		
Telephone:	( )	E-mail:
Social Security Number:	Sponsor: - -	Beneficiary: - -

TO THE BENEFICIARY: Please read the following and complete the information requested.

You have the right to inspect and obtain a copy of your protected health information maintained in our designated record set. You are not entitled to inspect or obtain a copy of any psychotherapy notes we may have; any information we may have compiled in anticipation of or for use in a civil, criminal or administrative proceeding, and certain other records. To exercise your right, please complete SECTION B.

SECTION B: PROTECTED HEALTH INFORMATION ACCESS REQUESTED.

Please specify the records to which you wish to have access:

Do you wish to: ❑ Inspect these records? ❑ Obtain a copy of these records?

You will be charged $0.10 per page to copy these records for charges in excess of $30.00.

Would you like TriWest to make these records available to you: ❑ On Paper ❑ Electronically

Would you like TriWest to **prepare a summary or explanation** of these records? You will be charged $15.00 for the summary or explanation. ❑ Yes ❑ No

Would you like TriWest to **mail** you copies of your records? You will be charged postage. ❑ Yes ❑ No

Please attach the names and address of each person, including yourself or your personal representative, for whom you would like us to make a copy. If you would like TriWest to provide access to, or a copy of your records to any person other than you or your personal representative, you must provide TriWest with a signed authorization. We can supply you with the required authorization form.

BENEFICIARY'S SIGNATURE: **Date** ____/____/______

If this request is by a personal representative on behalf of the beneficiary, complete the following:

Personal Representative's Name:

Relationship to Beneficiary:

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Please submit the completed and signed request to: TriWest Healthcare Alliance; Attn: HIPAA Privacy Official; P.O. Box 42049; Phoenix, AZ 85080-2049