AmeriHealth
ADMINISTRATORS

Request for Copies of Protected Health Information

Please Note: There is a fee required for all requests.

Last name appearing on records same as below, or: _____

☐ Mr. ☐ Mrs.☐ Ms. ☐ Miss

Last Name: _____ First Name: _____ Middle Name: _____

_____
Address: (Street/Apt. No./P.O. Box/R.R. No.)

_____
City/Town/State/Zip Code:

Telephone Number (Day): ( ) _____

Telephone Number (Evening): ( ) _____

Detailed description of requested records, personal information or personal information to be corrected. (If you are requesting access to or correction of your personal information, please identify the personal information bank or record containing the personal information, if known.)

_____

_____

_____

_____

Note: If you are requesting a correction of personal information, please indicate the desired correction and, if appropriate, attach any supporting documentation. You will be notified if the correction is not made and you may require that a statement of disagreement be attached to your personal information.

Preferred method of access to records:

- ☐ Examine Original
- ☐ Receive Copy

Signature: _____

Date: _____

For Internal Use Only

Date Received: _____ Request Number: _____

Comments:

_____

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Note: Personal information contained on this form is collected pursuant to the HIPAA Privacy Rule *and will be used for the purpose of responding to your request. Questions about this request should be directed to the Privacy and Security Office at AmeriHealth Administrators.*