# 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:

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.

To: _____
_____
_____

Enclosed is the form you have requested. Please complete and return all pages of the form to our attention:

AmeriHealth Administrators
Attn: Privacy Official
1900 Market Street, Suite 500
Philadelphia, PA 19103

Only fully completed forms will be accepted.
Forms must be typed or legibly written.
Forms must be signed and dated.

We will begin to process your request on the day it is received. If your request is denied for any reason, you will receive an explanation of the denial.