

JOHNS HOPKINS HEALTHCARE, LLC

Administering EHP, Priority Partners MCO, USFHP, Mercantile, Chester River and AON Health Plans (the "Plan")

REQUEST TO INSPECT AND OBTAIN COPY OF A DESIGNATED RECORD SET

I, _____, request access to _____
<insert name> <insert "inspect", "copy" or "inspect/copy">
 the following designated record set(s) for _____ :
<insert "myself" or another name>

- | | |
|--|--|
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Claims Adjudication Record |
| <input type="checkbox"/> Enrollment Record | <input type="checkbox"/> Case or Medical Management Record |
| <input type="checkbox"/> Payment Record | <input type="checkbox"/> _____ |

I request access to the above designated record set(s) covering the period of time:

_____ <insert to and from date(s)>

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable federal guidelines. I agree to pay any such fees upon signing this request.

Plan Member Name:	_____		
	<small>(first)</small>	<small>(m. initial)</small>	<small>(last)</small>
Signature:	_____	Date:	_____
Address:	_____		
	<small>(street address)</small>		

	<small>(city)</small>	<small>(state)</small>	<small>(zip code)</small>
Phone:	_____		
	<small>(area code)</small>	<small>(home phone number)</small>	
Plan Member #:	_____		
Birth Date:	_____		
<p>For healthcare agent/court appointed guardian/surrogate/custodial parent/informal kinship care relative or Personal Representative of the deceased, <small>(circle one of the above)</small></p> <p>I, _____, confirm that I am the representative for the plan member as <small>(print your name)</small> circled above.</p> <p>Representative's Signature: _____ Date: _____</p> <p>Address: _____ Phone: _____</p> <p>If you are the healthcare agent, court appointed guardian, relative providing informal kinship care or court appointed Personal Representative of the deceased, you must attach proof of your authority to act on behalf of the plan member.</p>			

If copies are requested and you would like the copies sent to a different address than you provided above or faxed to you, please fill in the following:

Plan Member/ Representative Name:	_____		
	<small>(first)</small>	<small>(m. initial)</small>	<small>(last)</small>
Mailing Address:	_____		
	<small>(street address)</small>		

	<small>(city)</small>	<small>(state)</small>	<small>(zip code)</small>
Fax Number:	_____	Phone:	_____
		<small>(area code)</small>	<small>(home phone number)</small>

1. I understand that I am not able to access the following health information:
 - a. That is not part of a designated record set;
 - b. Psychotherapy notes;
 - c. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; or
 - d. Information access to which is prohibited by law.
2. I understand that the Plan will respond to me within 30 days after the receipt of this request unless the records are not maintained or accessible on-site, in which event the Plan will respond within 60 days of the request. If the Plan is unable to respond within the 30 day or 60 day time period, the Plan may extend the time to respond (one-time only) for up to an additional 30 days, provided the Plan provides me with a written statement, within the 30 or 60 days as applicable, of the reasons for the delay and the date by which the Plan will respond.
3. If the Plan grants my request, the Plan will provide me with access to the requested information in the form or format requested by me, as long as the information is readily producible in that form or format. Otherwise, the Plan will provide me with access to the requested information in hard copy or another format we agree upon. The Plan may provide me with a summary or explanation of the requested information if I agree, before signature, to accept a summary or explanation and I agree, in advance, to pay a reasonable, cost based fee (if any) for the summary or explanation.
4. If the Plan grants my request, the Plan will provide access within the time specified in step 2 above, including arranging a time for me to inspect or obtain a copy of requested information. If I request, the Plan will mail me a copy of the requested information to the address on this form, or to the alternative address specifically provided on this form, or to the fax number specified on this form.
5. If the Plan denies part of my request, the Plan will, to the extent possible, give me access to the information requested that I am allowed to access.
6. I understand that the Plan may deny my request for access. I am not entitled to a denial review if :
 - a. I am not entitled to access the information I requested as stated in paragraph 1 above; or
 - b. The requested information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
7. I understand that the Plan may deny a request for access, but that I am entitled to have my denial reviewed, If the denial is due to:
 - a. a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger my life or physical safety or the life or physical safety of another person;
 - b. the requested information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
 - c. the request for access is made by my representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such representative is reasonably likely to cause substantial harm to me or another person.
8. If I am entitled to a denial review, I agree to complete the form titled "Request for Review of Denial of Access". I understand that a licensed health care professional designated by Johns Hopkins will review denials of access. The licensed health care professional will not have participated in the original decision to deny access. I will receive written notice, within a reasonable time, whether my request will be granted. I understand that the Plan will abide by the decision of the reviewer.