



Member Record Access Request

Member's Name: _____
 Last First Middle

Home Address: _____

Home Phone: _____ Date of Birth: _____

Health Plan Name: _____ ID#: _____

I hereby request that Saint Mary's ATRIO Health Plans provide me with a copy of:

(Please also check one of the two boxes below):

- I am only interested in accessing or obtaining a copy of individual payment information relating to the time period _____ through _____.
- I am only interested in accessing information for the period showing active eligibility with ATRIO in the form of a summary report prepared by Saint Mary's ATRIO Health Plans.

My request is for: Medical Pharmacy

For the following record types (check all that apply):

- Claims payment records
 - Date range: _____ through _____
 - Only Claims payment records related to an accident or injury
Please provide date of accident or injury: _____
- Service authorization records
- Enrollment records
- Case Management records
- Wellness and/or disease management program info

Please provide the requested information to me in:

- Electronic form (on a disc or other encrypted media) Paper form

I would prefer to have the requested information (select one):

- Emailed to me securely at this email address: _____
- Faxed to me at the following number: _____
- Mailed to me at the following address: _____

Signatures are required on next page

Signatures

Signature of Member (or Personal Representative*)

Date

Printed name of Personal Representative

Date

Relationship of Personal Representative to Consumer

By signing this form I understand that any information provided to me pursuant to this records request will not include **psychotherapy notes**, information compiled in reasonable anticipation of (or for use in) **a civil, criminal or administrative proceeding** or **other information limited or restricted by applicable law**.

Psychotherapy notes are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. However, the underlying protected Health Information from the individual's medical or payment records or other records used to generate excluded records or information remains part of the designated record set and subject to access by the individual.

I understand a health care provider or licensed health care facility may enter HIV test results into an individual's routine medical record. This information must be disclosed per the Health Information Portability and Accountability Act (HIPAA) regulations, 45 CFR 160 to 164.

I understand that Saint Mary's ATRIO Health Plans may deny this request under limited circumstances as provided for under federal and Oregon law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law; I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by my health plan. This person chosen will not have participated in the health plan's decision to deny my request.

I understand that Saint Mary's ATRIO Health Plans will notify me of its decision to deny my request in whole or in part, ATRIO will provide a denial in writing no later than within 30 calendar days of the request (or no later than within 60 calendar days if ATRIO has notified me on an extension). See 45 CFR 164.524(b)(2).

If ATRIO or one of its business associates does not maintain the PHI requested, but knows where the information is maintained, ATRIO will direct me where to direct the request for access. See 45 CFR 164.524(d)(3).

After you have completed AND signed this form, please return it to Saint Mary's ATRIO Health Plans at:

Saint Mary's ATRIO Health Plans
2695 Ryan Drive
Salem, Oregon 97301

or

Fax the request to: 1-866-298-8412

Note: Before the release of any information to someone other than the ATRIO Member, ATRIO must have (1) documentation of the legal status of Personal Representative or (2) a completed and signed Protected Health Information Disclosure Form. A response will be provided within 30 days, only after the proper authorization to release information as been received. Please call ATRIO Customer Service Call Center for additional information at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.