*Health Net Health Plan of Oregon, Inc. (Health Net)*

# Request to Access (See) Records

**NOTICE TO MEMBER:**

- The law states that you can ask Health Net to see or get a copy of your records. The law also states that you can ask for a written summary of your records if you don't want a copy of every record. You must ask by writing a letter or by using this form. Health Net will respond to your request within 30 days. The law also states that in some cases, Health Net does not have to let you see or get a copy of your records. If that happens, Health Net must send you a letter telling you why. Health Net may request an extension to provide your records. If we need more time, we will write a letter and tell you why we need the extension. The letter also tells you how to ask for a review and how to file a complaint.
- Personal representatives: You must give Health Net a copy of the legal papers showing your authority to sign this form.
- Charges: The law states that Health Net can charge for the cost of giving you a summary or a copy of your records. If there is a cost, Health Net will let you know before the summary or copy of your records is made.

## Member information

| | | | |
|---|---|---|---|
| Member name (print): | | | |
| Member date of birth: | | Member ID #: | |
| Address: | | | |
| City: | State: | ZIP: | Phone: |

## Check the box next to the records you want

- ☐ Records used to decide about my care (Case or Medical Management).
- ☐ Records about my claims and billing.
- ☐ My customer service records (phone call records).
- ☐ I want the records I list here: _____

## List the start and end date of the record you want

| | |
|---|---|
| Start date: | End date: |

## How would you like to receive your records? (please check the box next to your choice)

- ☐ I want a copy of my records.
- ☐ I want a summary that explains my records.
- ☐ Mail copy to address listed above (member information).
- ☐ Mail to address I list here:

_____

*(continued)*

## Member signature

| | |
|---|---|
| By signing this authorization, I acknowledge that I have read and understand the information provided on this form, and that my signature authorizes the disclosure of the information described above. | |
| Member signature (member or personal representative sign here): | Date: |
| If you are signing for the member, what is your relationship to the member? (Please provide documents showing your authority to sign for the member.) | |

**Mail completed form to:**

Health Net Health Plan of Oregon, Inc.

Attn: Compliance Department, PO Box 11756, Eugene, OR 97440-3940

Fax: 844-426-5340

Email: PMyInfo@trilliumchp.com