



## INDIVIDUAL REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

This form is to be used by a member, parent / guardian or personal representative to:

- Inspect protected health information (PHI).
- Obtain a copy of PHI.

This form applies to PHI records Gold Coast Health Plan (GCHP) creates or maintains pertaining to the designated record set.

### PART A: MEMBER INFORMATION

Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### PART B: REQUESTOR INFORMATION (If applicable)

Requestor Name: \_\_\_\_\_

Business (if applicable): \_\_\_\_\_

Phone Number: \_\_\_\_\_

### WHAT IS YOUR RELATIONSHIP TO THE MEMBER WHOSE PHI YOU ARE REQUESTING?

- ☐ I am the member.
- ☐ I am the parent or legal guardian of the minor member.
- ☐ I am the personal representative of an adult member (legal documentation must be provided if not on file).
- ☐ Other (written authorization to disclose health information of the member typically required).

### PART C: REQUEST FOR ACCESS TO PHI

#### PLEASE INDICATE THE PHI YOU WOULD LIKE TO ACCESS.

- |  |   |
|--|---|
| <input type="checkbox"/> Medical Claim Record(s)         | <input type="checkbox"/> Medical Authorization Request(s) |
| <input type="checkbox"/> Care Management Record(s)       | <input type="checkbox"/> Pharmacy Claim Record(s)         |
| <input type="checkbox"/> Pharmacy Prior Authorization(s) | <input type="checkbox"/> Notice(s) of Action              |
| <input type="checkbox"/> State Hearing Statement(s)      | <input type="checkbox"/> Eligibility Information          |
| <input type="checkbox"/> Other (please specify): _____   |   |

#### PLEASE SPECIFY THE DATES OF SERVICE TO ACCESS.

From date (month / day / year): \_\_\_\_\_ To date (month / day / year): \_\_\_\_\_



**HOW WOULD YOU LIKE TO RECEIVE THE PHI REQUESTED?**

- ☐ Paper ☐ Electronic File (provided through email)

**HOW WOULD YOU LIKE TO OBTAIN THE PHI INFORMATION?**

- ☐ Pick-up at Gold Coast Health Plan, 711 E. Daily Drive, Suite 106, Camarillo, CA 93010

☐ Mail: \_\_\_\_\_  
Street / Unit City State Zip

☐ Email (for electronic file requests): \_\_\_\_\_

☐ Fax: \_\_\_\_\_

**PART D: MINORS (If applicable)**

State and federal laws require minors over 12 years of age to consent to the release of the following types of records:

- Diagnosis and treatment of infectious, contagious or communicable diseases
- Sexually transmitted diseases
- Outpatient mental health services
- Drug / alcohol treatment or counseling

Minors of any age may consent to:

- Reproductive health care.
- Pregnancy care.
- Sexual assault / rape services.
- Emergency medical services.

In some cases, emancipated minors and minors 15 years of age and older may consent to general medical care if they live apart from their parent / guardian.

MINOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PART E: REQUESTOR'S SIGNATURE (Only if requestor is not the member)**

Requestor Name: \_\_\_\_\_

Requestor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART F: MEMBER'S SIGNATURE**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**When will I receive the requested information?**

- GCHP will process this request within **30 calendar days** from the date the form is received.
- If the PHI requested is not maintained or accessible to GCHP on-site, GCHP will process this request within **60 calendar days**.
- GCHP will inform you of the acceptance of the request and provide you with the requested PHI.

**How will I receive the requested information?**

- GCHP will provide the PHI in the format requested.
- If GCHP cannot readily provide the PHI in the format requested, the PHI will be made available on a hard copy form. Other formats may be used as agreed to.
- GCHP may charge a fee to cover the cost of copying records.

**Can my request be denied?**

- Your request may be denied if the information compiled is in reasonable anticipation of, or for use in, a legal proceeding.
- If your request is denied, GCHP will provide a written denial with an explanation. GCHP will let you know if you are entitled to have the denial reviewed.

**Submit the completed form to:**

Gold Coast Health Plan  
Attn: Compliance Department  
711 E. Daily Drive, Suite 106  
Camarillo, CA 93010

Fax: 1-805-437-5132