Request to Access Protected Health Information (PHI)

I hereby request access to my protected health information that CarePlus maintains in a set of specific record(s). CarePlus will consider the request and respond to me within 30 to 60 days. If CarePlus needs an extension of the 30 days, I will receive notice at that time. If my request is denied, CarePlus will send a written explanation of the reason for denial.

Please list the information requested – for example, dates of service or claims information for specific time periods – and time period of the requested information:

Information	Time Period
_____	from _____ to _____
_____	from _____ to _____
_____	from _____ to _____

Please check your preferred method of meeting this request:

☐ Mail to the address below.

☐ Request an in-person inspection of the information at a CarePlus facility. I can be contacted at the following daytime telephone number: _____

☐ Please send via secure email to my email address of: _____

☐ Please send via requested method: _____

CarePlus may impose costs/charges for supplies, labor, copying, and postage.

Please print the following information:

Member name: _____ Date of birth: _____

Member ID: _____ Daytime phone: _____

Address: _____

Alternative phone: _____

Member signature: _____ Date: _____

Legal representative signature: _____ Date: _____
(*only if member is unable to sign)

Relationship to member: _____

Please note: If you are a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member (e.g., healthcare power of attorney, healthcare surrogate, living will, or guardianship papers).

To prevent a delay in fulfilling your request, please verify all fields on this form are complete and accurate. If information is missing, we will return the form to you for completion. Please attach a separate sheet if you need more space.

Please send this form to:
Privacy Office
P.O. Box 1438
Louisville, KY 40202-1438

CarePlus
HEALTH PLANS™