

**SEAFARERS HEALTH AND BENEFITS PLAN**

**5201 Auth Way**

**Camp Springs, Maryland 20746**

**1 (800) 252-4674**

**REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION**

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Evening Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I am requesting a copy of my complete record for the following period (but not earlier than 4/14/03): date from: \_\_\_\_\_ date to: \_\_\_\_\_.

I am requesting claims information for the following claim(s):

provider: \_\_\_\_\_ date of service: \_\_\_\_\_

provider: \_\_\_\_\_ date of service: \_\_\_\_\_

provider: \_\_\_\_\_ date of service: \_\_\_\_\_

I am requesting other protected health information (please specify):

\_\_\_\_\_  
\_\_\_\_\_

I understand that I may access my health information through any of the following methods (check desired method):

I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to the Plan's office. I understand that I will be charged a fee for copying services.

I prefer to have the requested information copied and mailed to me. I understand that I will be charged a fee for postage and copying services.

I prefer to have a written summary of the requested information mailed to me. I understand that I will be charged a fee for preparing this summary.

Signature of Participant: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If signed by personal representative:

Name of personal representative: \_\_\_\_\_

Relationship to participant or nature of authority: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date