Request to Inspect and Copy Protected Health Information (PHI)

Complete the following with information about the person whose PHI is subject to this request:

Name (Last, First, MI):	
Address (City,State,Zip):	
Phone:	
Date of Birth:	

If you are not the employee, complete the following:

Employee Name:	
Employee ID #:	
Employee Date of Birth:	

I am requesting that I be allowed to inspect and copy my PHI in a designated record set maintained by the Plan as described below. I understand that I may be charged a fee for the costs of copying, mailing and other supplies.

If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this request. *(A personal representative may be requested to provide verification of representative status.)*

_____ _____

Signature of applicant or personal representative **Date**

Relationship of personal representative to member: _____

Send completed form to: **Privacy Official**
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251

Phone: (480) 312-7600
FAX: (480) 312-7960

FOR HUMAN RESOURCES USE ONLY

Request approved ☐

Extension needed ☐ Reason: _____

Date information will be provided: _____

Request denied ☐ Reason for denial_____

By: _____ _____ _____

COS Signature Date Name and Title