



## APWU Health Plan Request to Access Protected Health Information

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With this form, you may exercise your right to request access to Protected Health Information maintained by APWU Health Plan. This must be completed in its entirety to ensure your Protected Health Information can be located and released.

**Please print neatly to ensure accurate processing and to avoid delays in service.**

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**1. Member Information:**

Policy Holder/Member's ID# \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

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

Member's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

**2.** I am requesting access to the Protected Health Information maintained by the APWU Health Plan and its Business Associates. I understand that the APWU Health Plan does not, by law, have to provide me with certain information, including: (1) information that is not received by or maintained by APWUHP; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not subject to the right to access information under HIPAA. If the APWU Health Plan denies the requested access, the Requestor may appeal such denial.

**3.** Check one of the two options below:

- Receive a paper copy of my Protected Health Information to the address stated above.
- Visit the APWU Health Plan located in Silver Spring, Maryland to review and obtain a copy of my Protected Health Information.

**4.** I understand that I will receive a response to or be given the status of my request within thirty (30) days from the APWU Health Plan's receipt of the request.

**5.** Please mail this Access to Protected Health Information Request to:

APWU Health Plan  
Privacy Specialist  
799 Cromwell Park Drive, Suites K-Z  
Glen Burnie, MD 21061  
1-800-222-2798

