APWU Health Plan
Request to Access Protected Health Information

With this form, you may exercise your right to request access to only your 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.

1. **Requestor Information:**

   Requestor ID#: _____

   First Name: _____ MI: _____

   Last Name: _____ Date of Birth: ____/ ____ /____

   Address: _____

   City: _____ State: _____ Zip: _____

   Home Phone Number: _____ - _____ - _____ Work Phone Number: _____ - _____ - _____

   E-mail Address: _____

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 APWU Health Plan; (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.

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

   ☐ Receive a paper copy of my Protected Health Information to the address we have on file.

   ☐ Visit the APWU Health Plan located in Glen Burnie, Maryland to review and obtain a copy of my Protected Health Information.

   _____ _____
   Signature of Requestor Date

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

   APWU Health Plan
   HIPAA Privacy/Security Specialist
   799 Cromwell Park Drive; Suites K-Z
   Glen Burnie, MD 21061

   1-800-222-2798