

**WHY THIS FORM?**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to authorize another individual and/or entity to use and/or disclose your PHI in the Designated Record Set ("DRS") that is maintained by EHIM, Powered by ProCare Rx, or its Business Associate ("BA"). Please complete this form in its entirety so that we may provide you with the correct information you are requesting.

<b>A. Member Information</b>				
Last Name:		First Name:		Middle Name:
Date of Birth:		EHIM Member #:		Phone #:
Address:		City:		State: Zip:
<b>B. Authorization Information</b>				
1. <b>Description of Records.</b> The following is a description of the records I hereby request access to (i.e., all PHI or PHI related to a specific date, illness, or treatment):				
2. <b>Access to Records.</b> The records will be mailed to the member, unless specified below:				
A. I hereby request my records be mailed to the following individual and/or entity and address:				
Name:		Address:		
B. I hereby request that I have access to my records in person. I understand that a meeting will be arranged at a convenient time and location mutually agreed upon by both me and EHIM, Powered by ProCare Rx.				
3. <b>Denial of Request.</b> I understand and acknowledge that <b>EHIM, POWERED BY PROCARE RX, IS UNDER NO OBLIGATION TO AGREE TO THIS REQUEST TO ACCESS MY PHI</b> under the following conditions: (1) the information is not received and/or maintained by EHIM, Powered by ProCare Rx; (2) the information is compiled in reasonable anticipation of and/or for litigation; and (3) the information is not subject to the right to access information under HIPAA. I further understand and acknowledge <b>MY REQUEST TO MY DRS MAY BE DECLINED IF:</b> (1) the request is not reasonable and/or feasible; (2) the information I provide is not accurate; (3) this form is not completed in its entirety; and/or (4) I do not sign below. If EHIM, Powered by ProCare Rx, denies this request, it will provide me with a written explanation of the reason(s) and whether I have a right to further review.				
4. <b>Rights and Acknowledgement.</b> With certain exceptions, I have the right to access, inspect, and/or obtain a copy of my DRS. If I have any questions about access to my DRS, I may refer to the EHIM, Powered by ProCare Rx, Notice of Privacy Practices ("NPP") under HIPAA, which may be accessed on its website at <a href="http://www.ehimrx.com">www.ehimrx.com</a> and/or may be provided upon request by contacting EHIM, Powered by ProCare Rx, at 800-311-3446. By signing below, I hereby request to access, inspect, and/or obtain copies of my DRS. EHIM, Powered by ProCare Rx, will have up to thirty (30) days after receiving this request to act on it, and in certain circumstance, EHIM, Powered by ProCare Rx, may be permitted a one (1)-time, thirty (30)-day extension. I understand and acknowledge that this request for access to my DRS will involve time and preparation by EHIM, Powered by ProCare Rx, and that EHIM, Powered by ProCare Rx, reserves the right to charge a reasonable, cost-based fee for the following: (1) labor for copying; (2) supplies for creating a paper copy or electronic media; (3) postage; and/or (4) a summary preparation. The information described on this form is protected by law and shall only be used as indicated above, unless otherwise required and/or permitted by law.				
Signature:				Date:
If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative signed by the Member naming you as a personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.				
Signature of Personal Representative:				Date:
Print Name:				
Relationship:      Parent/Legal Guardian      Personal Representative      Other				
<b>C. TO BE COMPLETED BY EHIM</b>				
Request Approved. Effective Date _____ Request Denied. Reason _____				
Additional Comments:				
EHIM Representative Signature				Date:

If you have any questions, please contact the EHIM Privacy Officer at 800-311-3446. Please either fax this form to (248) 948-9904 or mail to: EHIM, Powered by ProCare Rx, ATTN: Privacy Officer, 26711 Northwestern Hwy, Ste 500, Southfield, MI 48033