DELTA HEALTH SYSTEMS
Administration Services

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act gives you the right to inspect and receive copies of certain health information. On behalf of your employer-sponsored health plan, Delta Health Systems (DHS) may be able to provide you with:

Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or on behalf of your health plan; or

Used, in whole or in part, by DHS or other business associate of your health plan to make decisions about your benefits.

DHS can also mail this information to someone else on your behalf. If you need a copy of your medical records, please contact your doctor or hospital.

You must complete all sections of this form. After you fill out the form, mail to:

Delta Health Systems | 3244 Brookside Road | Stockton, CA 95219 | ATTN: Privacy Officer
You may also fax the form to: (209) 939-3930

Please tell us what information you wish to receive: (dates of service, type of injury or illness, and name of your doctors, hospitals or other providers will help us to respond to your request faster):

_____

_____

_____

If DHS accepts your request, we will have your information ready for you within 30 days after receiving your request. If more time is needed, we will tell you. If DHS has to deny your request, you will be told why within 30 days after receiving your request.

DHS may charge you for the cost of copying and mailing your health information. The cost for copies is .25 cents for each page. The cost of mailing depends on how many pages are sent. Do you agree to pay these fees?

☐ Yes ☐ No

Do you want actual copies of this information, or would you like us to summarize it for you (check one)?

☐ Copy ☐ Summary

Do you want paper copies of this information, or would you like it in electronic form (check one)?

☐ Paper ☐ CD or thumb drive (Information will be sent to you encrypted.)

Who would you like to receive this information (check one)?

☐ You. (Information will be mailed to the address on file with DHS.)

☐ Third-party listed below:

_____

Name

_____

Street Address or P.O. Box

_____ _____ _____

City State Zip

I declare under penalty of perjury that the information on this form is true and correct.

_____ _____

Print name of plan participant HealthCare ID #

_____ _____

Signature of plan participant or personal representative Date

_____

Telephone number

Note: if you are acting as the personal representative of a plan participant, please tell us your relationship to the participant: _____

You may be required to show us proof of your legal permission to act for the participant.

Any attempt to falsely gain access to protected health information is subject to legal penalties.

Should you have questions about this form, please contact Delta Health Systems at the toll-free number listed on your ID card.