INSPECTION AND COPYING REQUEST FORM

Complete this form and return to: Privacy Compliance Administrator, Corporate Compliance, Capital District Physicians' Health Plan, Inc., 6 Wellness Way, Latham, New York 12110 or Fax: (518) 641-5504

I. MEMBER INFORMATION

Date of Request: _____ Date of Birth: _____

Name: _____

CDPHP Identification #: _____Telephone Number: _____

II. REQUESTED INFORMATION

Describe the information to be sent:

_____

III. ADDRESS INFORMATION

CDPHP should provide my records to: _____ Self _____ Other

Recipient Name: _____ Phone: _____ Fax:_____

Recipient Mailing Address: _____

Recipient Email: _____

IV. METHOD

_____ Paper

_____ Email (Encrypted) - In an effort to protect your health information, our standard practice is to encrypt our email.

_____ Email (Unencrypted) - Signature Required - By signing you acknowledge that you understand an unencrypted email exposes your health information to additional security risks.

Signature: _____

V. SIGNATURE

I am requesting access to the above referenced information in my capacity as *(select one):*

_____ Self _____ Parent _____ Guardian _____ Legal Representative *(attach signed authorization form)*

_____ Other (explain): _____

Signature of member or legal representative: _____ Date:_____

If you require your health information in a format other than paper or email, please contact us at (518) 641-5213.