INSPECTION AND COPYING REQUEST FORM

Complete this form and return to: Privacy Compliance Administrator, Corporate Compliance, Capital District Physicians' Health Plan, Inc., 500 Patroon Creek Blvd., Albany, New York 12206-1057 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

Indicate the address where the information should be sent:

_____

_____

_

IV. 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_____