MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Participant Name:_____ Social Security Number: _____

Address: _____

_____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____ Participant Birth Date: _____

I hereby request a copy of my health information from the MPI Health Plan for the following dates:
_____.
I request the health information contained in the following records (please check one or more):

____ enrollment
____ premium/contribution payment
____ case or medical management
____ claims, billing and EOB information relating to the following service or claim: (specify date of service and/or medical condition)_____
_____
____ other (please specify)_____

I understand that I may access my health information through any of the following methods (please check the desired method):

____ I prefer to inspect and/or have copied by the MPI Health Plan the requested information in person and will arrange for a mutually convenient time to come to the MPI Health Plan by calling 818 or 310 769.0007, Ext. 244. I understand I will be charged a copying fee of $1.00 per page.

____ I prefer to have the requested information copied and mailed to me at my address of record, noted above. I understand I will be charged a copying fee of $1.00 per page, and a postage fee for First Class mail.

____ I prefer to receive a written summary of the requested information, instead of the complete records, for the fee of $_____.

_____ ____/____/____
Participant Signature *Date*

If this Request for Access is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the MPI Health Plan.

If signed by personal representative, name of personal representative: _____

Relationship to Participant or nature of authority:_____

_____ ____/____/____
Signature of Personal Representative *Date*

THIS REQUEST MUST BE COMPLETED IN FULL BEFORE BEING SUBMITTED