INDIVIDUAL REQUEST TO INSPECT AND/OR COPY PROTECTED HEALTH INFORMATION

I request to review protected health information held about me in the Loyola University New Orleans Employee Benefit Plan (the "Health Plan") "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). A "designated record set" includes information such as medical records; billing records; enrollment, payment, claims adjudication and health plan case or medical management record systems; or records used to make decisions about individuals.

I understand that the Health Plan has 30 days to respond to this request. I also understand that the Health Plan has a right to a one-time extension of the foregoing time periods for an additional 30 days if it provides me with written notice of the reasons for the delay and the date by which the Health Plan will complete its action on my request. I further understand that the Plan may charge me a fee for the cost of the supplies and labor of copying the PHI and the postage associated with mailing the PHI.

I request the following information:____

I request that the information be provided in the following format (circle one): Paper Electronic

If a summary is requested: Summary only ☐ Detailed information and summary ☐

I agree to pay any fees for copying or summarizing my protected health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I request a summary).

I understand that this request does not apply to certain protected health information, including: (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation, or any other civil, criminal, or administrative action or proceeding; and (4) other information not subject to the right to access information under HIPAA.

If the Plan uses or maintains an electronic designated record set with respect to my protected health information, I understand that I am entitled to copies of my protected health information in an electronic format, if it is readily producible, or if not, in a readable electronic form and format agreed to by the Plan and myself.

(Optional: Use only if you wish PHI to be transmitted directly to a third-party) I have the right to direct the Plan to transmit a copy of the Electronic Health Record directly to a third party I wish for my PHI to be directly transmitted to the following person/entity:

Name of third-party: ____

Physical or email address of third-party: ____
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NOTE: If information is sent via email, that information may not be encrypted.

Signature: _____________________________________ Date:_______________

Please mail or fax the completed Form to: Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax).

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