Michigan Conference of Teamsters Welfare Fund
Individual Request for Access to Protected Health Information

Section #1: Individual Information

I certify that I am (check all that apply):

☐ A participant (employee/retiree)

☐ A participant's spouse or surviving spouse

☐ A non-spousal dependent of a participant

☐ A personal representative*

Name of Participant: _____ _____
(print name)

Participant's Contract Number: _____-_____-_____ Participant's Birth Date: _____/_____/____
MM / DD / YR

You can contact me at:

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

I am requesting access to health information for (check only one):

☐ Myself (print name)_____

☐ My dependent minor child (print name)_____

☐ A covered individual for whom I am the personal representative* (print name)_____

**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete the personal representative area found in Section #3. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

Section #2: Request for Access

I, _____ (print name), hereby request a copy of the health information for the identified individual in Section #1 from the Michigan Conference of Teamsters Welfare Fund (MCTWF) for the following dates:

_____

_____

_____

I request the health information contained in the following records (check all that apply):

☐ enrollment

☐ contribution payment

☐ case or medical management

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☐ claims, billing and EOB information relating to the following service or claim: (specify date of service and/or medical condition)

_____

_____

☐ all of the above

☐ other (please specify) _____

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

☐ I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to the MCTWF Office by calling (313) 964-2400.

I understand I will be charged a copying fee of 15¢ per page.

☐ I prefer to have the requested information copied and mailed to the following address:

_____

_____

_____

I understand I will be charged a copying fee of 15¢ plus actual postage costs.

☐ I prefer to receive a written summary of the requested information, instead of the complete records. I understand I will be charged a minimum fee of $10.00 plus an additional charge for time spent preparing the summary.

I, _____ (print name), have reviewed this form and understand its contents. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____ Date of Signature
Signature MM DD YY

Address: _____

_____

_____

Section #3: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: _____
(print name)

Name of individual you are representing: _____
(print name)

Relationship to individual or nature of authority (e.g., parent of an unemancipated minor, unlimited guardian pursuant to letters of authority, personal representative pursuant to letters of authority, parent advocate pursuant to a health care power of attorney, other statutory authorization): _____

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Note: You must provide valid and current proof of your legal relationship as a personal representative.

Personal Representative Contact Information

Address: _____

_____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

_____ _____/_____/_____ Date of Signature

Signature of Personal Representative MM DD YR

Section #4: Submission Instructions

Submit Form to: Privacy Officer
Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216