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

Section #1: Requesting Individual

Name _____ Birth Date _____/_____/_____
Please Print

Contract Number _____ or Social Security Number _____
(Found on ID card)

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ E-mail _____

Section #2: Information to be Accessed

I 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 date(s):

_____

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

☐ enrollment ☐ self-contribution payment

☐ medical documentation relating to the following service or claim determination: (specify service and/or medical condition) _____
_____

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

☐ other (please specify) _____

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

☐ 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.*

Section #3: Access Method

I request access to the health information as follows (check the desired method):

☐ I wish 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 wish to have the requested information sent electronically to the following:

E-mail address: _____

Fund policy requires that email communication of PHI be sent in a secured manner

If a format other than PDF is requested, please specify:_____

☐ I wish to have the requested information saved electronically on portable media and mailed. *I understand I will be charged for the actual cost of supplies and postage.*

☐ I wish to have the requested information copied and mailed to:

Recipient Name _____

Address_____

City _____ State _____ ZIP Code _____

Section #4: Authorization and Signature

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

_____ Date of Signature _____/_____/_____
Signature

Address_____

City _____ State _____ ZIP Code _____

☐ I am the personal representative for the member.*
**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete Section #5. 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 #5: 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., health care power of attorney, guardian, other statutory authorization):

_____*Note: If other than natural parent of a minor child, valid and current proof of legal relationship as personal representative must be provided.*

Personal Representative Contact Information

Address: _____ Telephone Number: _____

_____ E-mail: _____

_____ Date of Signature _____/_____/_____
Signature of Personal Representative

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

Or Fax to: ***313-496-2943***