SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

REQUEST TO INSPECT AND / OR COPY PROTECTED HEALTH INFORMATION

Participant Name: _____ Date of Birth: ____/____/____

Social Security # xxx-xx-_____

Address: _____

_____

_____

Daytime Phone Number: _____ Evening Phone Number: _____

[ ] I am requesting a copy of my complete record for the following period (but not earlier than 4/14/03);
From date: _____ To date: _____.

[ ] I am requesting claims information for the following claim(s):
provider: _____ date of service: _____
provider: _____ date of service: _____
provider: _____ date of service: _____

[ ] I am requesting other protected health information (please specify):

_____

_____

I understand that I may access my health information through any of the following methods (check 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 Plan's office. I understand that I will be charged a fee for copying services.

[ ] I prefer to have the requested information copied and mailed to me. I understand that I will be charged a fee for postage and copying services.

[ ] I prefer to have a written summary of the requested information mailed to me. I understand that I will be charged a fee for preparing this summary.

Signature of Participant: _____ Date____/____/____

If signed by personal representative:

Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ ____/____/____

Signature of Personal Representative Date