REQUEST TO ACCESS, COMMUNICATE, OR AMEND PROTECTED HEALTH INFORMATION (PHI)

HIPAA Privacy Policy Form – For PHI Related to MPC Benefit Plans

Member Name (Please print)	**SSN or Employee ID #**
Patient Name (please print) and SSN	**Relationship to Member**
Address	**Email address**
Primary Contact Number	**Best time to be Contacted**

I request to access, communicate, or amend PHI held by the following MPC Benefit plan(s) as specified below. (Check all Plans for which this request applies.)

___ Health Plan
___ Dental Plan
___ Vision Plan
___ Health Care Flexible Spending Account Plan (HCFSA) Plan
___ Retiree Health Plan
___ Pre-65 Retiree Dental Plan
___ Pre-65 Retiree Vision Plan
___ Employee Assistance Program
___ Exchange Health Reimbursement Account (EHRA)

☐ **Request to Access or Inspect PHI**

I request access to the PHI maintained by the above Plan (including enrollment, payment, claims adjudication, health plan case management or medical management, and any other records used by or for the Plan to make decisions about me).

☐ **Request to Copy PHI**

I request a copy of the PHI maintained by the above Plan (including enrollment, payment, claims adjudication, health plan case management or medical management, and any other records used by or for the Plan to make decisions about me) be mailed to me at the following address in the format specified below:

Address: _____

Format: ☐ Paper ☐ Electronic

☐ **Request to Communicate PHI to a Third Party**

I request a copy of the PHI maintained by the above Plan (including enrollment, payment, claims adjudication, health plan case management or medical management, and any other records used by or for the Plan to make decisions about me) be mailed to the individual designated below at the following address in the format specified:

Name of Designated Individual: _____

Address: _____

Format: ☐ Paper ☐ Electronic

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☐ **Request to Amend PHI**

I have reviewed the PHI maintained by the above Plan (including enrollment, payment, claims adjudication, health plan case management or medical management, and any other records used by or for the Plan to make decisions about me) and request the following amendments to the PHI:

_____

_____

_____

_____

(Attach documentation of revisions, as applicable.)

Authorization:

I understand that the Plan has 30 days to respond to this request. However, if the Plan is unable to take action within the initial 30-day period, then the Plan may extend the time for such action by an additional 30 days, provided the Plan gives me a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request within the first 30-day period.

I understand that if the Plan agrees to this request, in whole or in part, it will inform me of the acceptance of the request and provide appropriate access. I understand that the Plan may need to follow up with me about a mutually convenient time and place for me to access and inspect the requested PHI. However, if the Plan denies the request, in whole or in part, as permitted by HIPAA, it will provide me with a written denial.

I agree to pay any fees permitted by law for providing access, copies, or explanations of the requested PHI. Fees will be reasonable and cost-based and will include only the cost of the following: labor for copying, supplies for creating or providing copies, postage (if applicable), and preparation of the information.

I understand that this request does not apply to certain health information, including information that is not held in the specified Plan, psychotherapy notes, information that is compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding, and other health information that is not subject to the right to access and amend information under HIPAA.

Signature of Individual: _____ **Date:** _____

FOR ADMINISTRATIVE USE ONLY (To be completed by HIPAA Privacy Officer):

Date received: _____

Action Taken: _____

_____

HIPAA Privacy Officer Signature: _____ **Date:** _____

Return completed form to:

MPC Benefits
Attn: HIPAA Privacy Officer
539 South Main Street, Findlay, OH 45840
privacy@marathonpetroleum.com