REQUEST TO ACCESS HEALTH INFORMATION

Health Plan of San Joaquin | Mountain Valley Health Plan

The Health Insurance Portability and Accountability Act gives you the right to inspect and receive copies of certain health information. Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") may be able to provide you with your enrollment, payment, claims, and medical or case management records. We can also mail this information to someone else on your behalf. If you need a copy of your medical records, please contact your doctor or hospital.

You must complete the entire form. Once the form is completed, you may mail or bring it to the following address:

Health Plan of San Joaquin/Mountain Valley Health Plan
7751 South Manthey Road
French Camp, CA 95231-9802

You may also fax the form to: **1-209-461-2550** or send to Health Plan through a secured email.

Please tell us what information you wish to receive: (dates of service, type of injury or illness, and name of your doctors, hospitals or other providers will help us to respond to your request faster):

If the Health Plan accepts your request, we will have your information ready for you within 30 days after receiving your request. If more time is needed, we will notify you.

If the Health Plan has to deny your request, you will be notified of the reason within 30 days after receiving your request.

The Health Plan may charge you for the cost of copying and mailing your health information. The cost for copies is .25 cents for each page. The cost of mailing depends on how many pages are sent. Do you agree to pay these fees?
☐ Yes ☐ No

Do you want actual copies of this information, or would you like us to summarize it for you (check one)?
☐ Copies or ☐ Summary

How would you like us to deliver your health information (check one)?		
☐ Mail to the person listed below:		
Name:		
Street Address:		
City:	State:	Zip Code:

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☐ Mail to you.
☐ In-person. Our office is open Monday through Friday from 8:00a.m– 5:00p.m. Please tell us a day and time when you would like to visit the Health Plan office and meet with a Customer Service Representative: Month and day: _____ Time: _____
☐ Other:

…… ……

Print Name of Member **Health Plan ID Number**

…… ……

Signature of Member or Personal Representative **Date**

……

Telephone Number

Note, if you are acting as the Personal Representative of a member, please tell us your relationship to the member:

……

Relationship to Member