REQUEST FOR RECORDS
CONTAINING PROTECTED HEALTH INFORMATION (PHI)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (HNFS) on behalf of the TRICARE program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: This information allows HNFS to process your request for a copy of your records as contained in a designated record set maintained by HNFS or one of its business associates.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any PHI in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

DISCLOSURE: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request.

Please submit the completed request to:

Health Net Federal Services, LLC
Attn: Privacy Compliance Office
10730 International Drive
Rancho Cordova, CA 95670
FAX: 1-844-813-7788

SECTION A: INDIVIDUAL/BENEFICIARY INFORMATION

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)

Address	City	State	ZIP

Telephone Number ( )	Email Address (optional)

Sponsor Social Security Number (SSN)	OR	Beneficiary DoD Benefits Number (DBN)

SECTION B: WHAT TYPE OF RECORD COPIES DO YOU WISH TO OBTAIN?

Note: Health Net Federal Services does not maintain provider medical records. Please contact the provider or facility that rendered the care for this information.

You may not have the right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a legal proceeding; or certain other records.

If reproduction costs exceed $30.00, HNFS may impose charges. You will be contacted if charges apply.

- ☐ AUTHORIZATIONS/REFERRALS
- ☐ CASE/CARE MANAGEMENT RECORDS (behavioral, health, physical health, ECHO)
- ☐ DISEASE MANAGEMENT PROGRAM RECORDS (anxiety, asthma, CHF, COPD, depression, diabetes)
- ☐ ENROLLMENT PAYMENT/FEE HISTORY
- ☐ EXPLANATIONS OF BENEFITS (EOB)
- ☐ OTHER: please describe _____

SECTION C: I AM REQUESTING RECORD COPIES FOR THE FOLLOWING DATES OF SERVICE

FROM DATE (mm/dd/yyyy):	TO DATE (mm/dd/yyyy):

Please Note: Health Net Federal Services maintains records six years from date of service; records created prior to this date may not be available.

Requests for records are generally completed within 30 calendar days; however, an extension may be requested.

SECTION D: HOW DO YOU WISH TO RECEIVE THE RECORD COPIES?

☐ Paper copy by U.S. Postal Service Certified Mail or United Parcel Service (UPS).

☐ Electronic copy (of information maintained within an electronic health record), if available. You must provide an email address in Section A. Any information we send will be encrypted.

Optional:

☐ Please send my records to the person designated below (an additional HIPAA compliant Authorization for Disclosure form may be required).

Name	Telephone ( )		Email Address
Address	**City**	**State**	**ZIP**
Relationship to the Beneficiary			

SECTION E: SIGNATURE

I DECLARE UNDER PENALTY OF PERJURY THE INFORMATION ON THIS FORM OR ATTACHED IS TRUE AND CORRECT. ANY ATTEMPT TO FALSELY GAIN ACCESS TO PHI IS SUBJECT TO LEGAL PENALTIES.

_____ _____

Signature of Beneficiary or Personal Representative* Date (mm/dd/yyyy)

_____

Print name of Personal Representative

*If this request is signed by a personal representative on behalf of the beneficiary, check the box that describes the relationship to the beneficiary and attach documentation of authority (for example, power of attorney, guardianship, custody documents).

☐ Parent of minor child ☐ Legal guardian ☐ power of attorney ☐ Executor ☐ Other

Please retain a copy of this request for your records.

FOR INTERNAL USE ONLY: (Circle One) APPROVE DENY

Date: _____ Deny Reason: _____

Initials: _____ _____

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