Request for Access to Inspect or Copy Protected Health Information (PHI)

1. Your Name _____ **2. SSN or ID#:** _____ **3. Date of Birth** ____/____/____

4. Mailing Address _____

Street City State Zip

5. Request for Access to Protected Health Information
I request access to protected health information (PHI) about me in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

6. Please indicate what specific information you are requesting: _____

_____

7. Check any of the below that apply

☐ I want to inspect PHI about myself
☐ I want to obtain a copy of PHI about myself
☐ I request that a copy of PHI about myself be mailed to the following address:

_____

I request that the information be provided in the following format:

☐ Paper
☐ Electronic

I understand that if the format requested is not readily producible, the Plan will provide a readable hard copy form or such other form or format as agreed to by the Plan and by me.

8. Other Important Information
I understand that the Plan has 30 days to act on this request. If the J.R. Simplot Company Group Health & Welfare Plan does not keep the information requested, the Privacy Officer will direct the requestor to the appropriate organization. If the Plan is unable to take action within the applicable time period, the Plan may extend the time for such action by 30 days provided that the plan, within the applicable time period, gives me written notice of the reasons for the delay and the date by which the Plan will complete its action on the request. If access is granted, the Privacy Officer or appointed designee will arrange a convenient time for access.

_____ _____

9. Participant's Signature Date