



# Health Insurance Risk-Sharing Plan HIPAA PRIVACY ACCESS REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require the HIRSP Authority, as a covered entity, to implement processes that give policyholders certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Completing this form is voluntary. However, if you would like an accounting of the disclosures that HIRSP or our business associates have made of your protected health information, you must provide all of the information requested on this form.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

**INSTRUCTIONS:** Mail this completed form to the following address:

HIRSP  
P.O. Box 8961  
Madison, WI 53708-8961

## SECTION I — POLICYHOLDER INFORMATION

Name — Last, First, Middle Initial	HIRSP Policyholder Number
Address — Street, City, State, ZIP Code	Telephone Number  (       )

Check this box if you want your health information records mailed to a different address. If so, complete the information below.

Alternate Address — Street, City, State, ZIP Code

## SECTION II — ACCESS POLICY SUMMARY AND REQUEST

You have the right to see or copy enrollment, claim, or other records used to make decisions about your health care coverage benefits by HIRSP. HIRSP will not include information prepared for legal actions or proceedings, criminal investigations or prosecutions, notes made by a mental health therapist or psychiatrist, and certain other records. Complete this form to request access to enrollment, claim, or other records used to make decisions about your health care coverage benefits by HIRSP.

Specify the records to be inspected or copied:

- enrollment
- claim
- other (please specify)

Specify the time frame of the records to be inspected or copied:

- 1 month \_\_\_\_\_
- 3 months \_\_\_\_\_
- 6 months \_\_\_\_\_
- other \_\_\_\_\_

- I want a copy of these records
- I want to inspect these records

You may be charged a fee for the costs of copying, mailing, or for other supplies needed to fulfill your request. You will be notified of any costs prior to receiving the requested copies.

If you want us to provide copies of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

*Continued*

**For more information about HIRSP, visit our Web site at [www.hirsp.org](http://www.hirsp.org)**

**SECTION III — SIGNATURES**

Please sign the form and complete the appropriate information.

<b>SIGNATURE</b> — Policyholder	Date Signed
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**If this request is by a personal representative on behalf of the policyholder, provide a copy of the documentation to support the representation and complete the following:**

Name — Personal Representative	Relationship to Policyholder
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<b>SIGNATURE</b> — Personal Representative	Date Signed
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