Privacy Request Form

Date of Request: _____

To request member information from MARYLAND PHYSICIANS CARE, please check one or more of the boxes below.

- ☐ Receive copy of privacy practices.
- ☐ Receive claim records.
- ☐ Change something in member records.
- ☐ Receive list of organizations to whom MARYLAND PHYSICIANS CARE gives out member records.
- ☐ Limit how MARYLAND PHYSICIANS CARE uses and gives out member records.
- ☐ Deny the release of Personal Health Information beyond the use for treatment, payment or health care operations.

Member Name: _____Date of Birth: _____ID #:

Phone: (_____)

Are you the member? Yes No **If "NO", tell MARYLAND PHYSICIANS CARE who you are by checking one of the boxes below. Please give MARYLAND PHYSICIANS CARE copies of papers that show you have the right to make this request.**

- ☐ I am the member's Dad/Mom or guardian.
- ☐ I make health care decisions for the member.
- ☐ The member has died, and I take care of his or her estate.
- ☐ Other (explain) _____

Name of Requestor (if not member):

Please Explain Your Request

Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. [MARYLAND PHYSICIANS CARE] Maryland Physicians Care may charge you to receive copies of member records or a list of people and companies to which we give out member records. You need to tell MARYLAND PHYSICIANS CARE if you can not pay any fee.

_____

_____

_____

Where Do You Want The Records Sent

Address: _____
Street City, State Zip

I (the member or person acting for the member) agree to the following:

- I may authorize Maryland Physicians Care to use or give out member records. When I give an approval, Maryland Physicians Care will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to [Maryland Physicians Care] a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Maryland Physicians Care's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell the Maryland Physicians Care when and the reason I want it to end. Use the space below to explain:

_____

- I have read and understand this form.
- I am entitled to receive a copy of this form.

_____

If member - Signature of Member Date

_____

If member -Print Member Name

Please send this Privacy Request Form to:

Maryland Physicians Care
Privacy Officer or Coordinator
1201 Winterson Road, 4th Floor
Linthicum Heights, MD 21090

Call Maryland Physicians Care at 800-953-8854 with questions or comments.

Revised: 06/17