Group Insurance Trust of the
California Society of Certified Public Accountants
Request for Access to Health Information

Please provide the information below. We cannot respond to your request without this information.

Your name: ____

Employee's name: ____ Employee's ID: __________________

Use this form to request to inspect or obtain a copy of your health information maintained by the Health Plans and used to make decisions about your Health Plan benefits. However, please note that we, the Health Plans, will not give you access to health information records created in anticipation of a civil, criminal, or administrative action or proceeding. You must identify the health information you would like to review or copy. You must also specify the form or format in which you would like to access your health information. The Health Plans will make reasonable efforts to accommodate your request to access your health information in a particular form or format.

This request applies to my following health information (describe the specific information or category of information):

Apply this request to the following Health Plans:

- ❑ CalCPA Health Medical Plans (PPO)
- ❑ Anthem Blue Cross Medical Plan (HMO)
- ❑ Vision Service Plan (Vision Plan)
- ❑ Delta Dental (Dental Plan)
- ❑ Other

Specify how you want to access your health information:

- ❑ Mail a hard copy of my requested health information records to the address provided below.
- ❑ Other

If your request for access to your health information is granted, the Health Plans will contact you to arrange a convenient time or place to inspect your health information. If you have requested a copy of the information, your health records will be sent to the address you provide on this form. You may be charged for the cost of copying and/or mailing copies of your records. You will be notified in advance of any such charges.

For internal use only:

❑ Approved Notice of extension sent: ____________________________________

❑ Denied Date received: ___________________________ Response Date: _______________________

Policy Attachment _________ 10452739

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The Health Plans may deny or partially deny your request to inspect and copy your health information if (1) a licensed health care professional hired by the Health Plans has determined that giving you the requested access is reasonably likely to endanger the life or physical safety or you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person, and that the requested access would likely cause substantial harm to the other person, (2) the information was received under a promise of confidentiality, and giving you access to he information would reveal the source of the information. In the unlikely event that your request to inspect or copy your health information is denied or partially denied, you will receive a written notice explaining the decision and the process for appealing the decision.

I hereby request access to my health information, as described above. **I understand that I may be charged for the cost of copying and mailing my health records.**

______________________________ ______________________
Signature* Date

**If you are making this request on behalf of another individual, a completed Personal Representative Form must be on file with the Health Plans unless you are the individual's parent or guardian and you are also a participant in a Health Plan.*

If you have requested the Health Plans mail you a copy of your health information, please provide the address where the information should be sent:

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Send this completed request form to:

Banyan Administrators, LLC
Managers for the CalCPA Health Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Fax – (877) 237-4519
calcpahealth@fnrm.com

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC at (877) 480-7923.

Policy Attachment _________ 10452739