First MEDICAL HEALTH PLAN, INC.

ACCESS TO PROTECTED HEALTH INFORMATION (PHI) FORM
(For purposes ***not*** related to Treatment, Payment, or Health Care Operations)

You have the right to inspect and receive an electronic or printed copy of your Protected Health Information, within the limits and exceptions provided by law. First Medical may deny your request to inspect and obtain a copy under certain limited circumstances. First Medical may charge you a reasonable fee to cover expenses related to your request.

I. Beneficiary/Subscriber Information: (Please use print letter)			
Name: Initial: Last Name:			Date of Birth:
Postal Address:			Contract Number:
Home Phone Number:	Mobile Phone Number:		Work Phone Number:
Other Phone Number:			Best time to call:
Email Address: _____ ☐ I authorize First Medical to send information to my email in a secure manner (Encrypted).			
My protected health information (PHI) will be used or disclosed for the following purposes: (Please choose an option) ☐ Subscriber/Dependent Request	☐ Judicial Proceeding	☐ Other (Specify)	
I. Indicate how you want to receive the requested information:			
☐ Postal Mail	☐ Email Address	☐ Fax	☐ On Hand
II. Information of the person or organization to receive Protected Health Information			
Name:		Position/Relationship:	
Postal Address:			
Phone:	Fax:	Email Address: ☐ I authorize First Medical to send information to my email in a secure manner (Encrypted)	
III. I authorize the use and disclosure of the following Protected Health Information: (select all that apply)			
☐ Payment History ☐ Hospitalization History	☐ Utilization History ☐ Emergency Room History	☐ Pharmacy History ☐ Laboratories History	☐ Provider Information: ☐ Others:
IV. Requested Period: From-		**To-**	

By signing this document, I am authorizing First Medical Health Plan, Inc., to use and disclose my Protected Health Information (PHI) for purposes ***not related*** to Treatment, Payment, or Health Care Operations. The persons or entities that I authorize to receive my protected health information may not be subject to the regulations of the Health Insurance Portability and Accountability Act (HIPAA) or any other federal or local health information privacy laws. The information to be used or disclosed pursuant to this authorization may

include data related to: (1) AIDS or HIV, (2) Treatment for Drug Abuse or Alcohol Abuse, or (3) Mental or Behavioral Health or Psychiatric Treatment.

This request can be revoked at any time by notifying in writing to:

First Medical Health Plan, Inc.
Privacy Unit
PO Box 191580
San Juan PR 00919-1580

The revocation will have no effect on any information that was already used or disclosed by First Medical prior to receiving written notification. I understand that the information disclosed pursuant to this authorization may be disclosed by the recipient to third parties and therefore will not be protected under the federal laws or state laws of Puerto Rico.

Incomplete forms will not be processed. All fields are required, unless otherwise specified. Please complete and sign.

Beneficiary/Subscriber's Signature: _____ Date: _____

If you are a Beneficiary/Subscriber's Legal Representative, you must:

1. Indicate your full name: _____ Date _____
2. Describe your authority to act on behalf of Beneficiary/Subscriber (for example: power of attorney, court order, etc.) _____
3. Provide a copy of the legal document that names you as Legal Representative. A representation document from Social Security is not admissible for purposes of this form (please request assistance from a Customer Service Representative).

If you have questions about this form, you may contact First Medical at 787-474-3999, ext. 2108.