



REQUEST FOR ACCESS TO RECORDS

Use this form if you would like to inspect or receive a copy of information Lipa maintains about you. This form must be complete and signed in order for Lipa to process your request.

Patient Name: _____ Date of Birth: ___/___/___ Phone #:(____)_____

Mailing Address: _____

Member ID#: _____

Description of Records Requested. Please check the boxes that describe the type of Lipa-generated records you are requesting and tell us the time period for the records, if applicable.

- Enrollment records
- Case or medical management records
- Customer Service records
- Claims, billing and Explanation of Benefits (EOB) information relating to the following date of service and/or medical condition:

- Other (please specify)

Time Period Requested: From _____ to _____.

Scope of Request. Please let us know if you want to inspect your records, copy your records, or both. I understand there may be a charge for this request.

- I would like to inspect the records.
- I would like to have the requested information copied and mailed to me.
- I would like to receive a written summary of the requested information, instead of the complete records.

I hereby request a copy of my health information from Lipa. I understand Lipa will provide a response to this request within thirty (30) days. I understand there is a charge of \$15.00 for materials provided. I further understand that Lipa may or may not approve this request. If I am denied, I may be able to have my request reviewed.

Please sign and date:

Member or Representative's Signature

Date

Printed Name of Representative

Relationship to Member

**Please mail to Lipa at P.O. Box 11740, Eugene, OR 97440-1740 or fax to 541-434-1291.
If you have questions, please contact Lipa's Privacy Officer at
541-762-9086 or toll-free 1-877-600-5472, TTY 1-877-600-5473.**