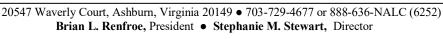
CONSUMER DRIVEN HEALTH PLAN

NATIONAL ASSOCIATION OF LETTER CARRIERS



HEALTH BENEFIT PLAN





Request for Access to Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right of access to inspect and obtain a copy of certain protected health information (PHI) that is maintained in a designated record set by the NALC Health Benefit Plan or its business associates. Please complete and sign this form if you wish to request access to the PHI we maintain.

| Section A - about the person whose PHI you're requesting (Patient) | | | | |
|--|--|---|---|---------|
| Member # | Patient's name | | | |
| Patient's date of birth | | | | |
| Section B - about you, the per | rson requesting access to the P | HI | | |
| Your name | Dayt | ime phone () | | |
| Your relationship to Patient (examples: se | lf, parent, personal representati | ve, power of attorney) | | |
| Your mailing address | | | · · · · · · · · · · · · · · · · · · · | _ |
| City | State | Zip | | |
| Section C - about your reques | it | | | |
| psychotherapy notes; informat subject to the right to access in | ion compiled in reasonable anti- nformation under federal law. | cipation of litigation or | ed by the NALC Health Benefit Plan; for litigation; and other information r | not |
| not be provided electronically, shown below, for the production sent by U.S. Postal Service fire | such as by fax or e-mail. NALC on and mailing of copies and sur st class mail. By submitting th i | Health Benefit Plan m mmaries. You will not b is request, you agree | summary of the information. Materi ay charge reasonable cost-based for be charged the cost of postage for n to pay the fees, if charged. | ees, as |
| | hich you would like access: (che | , | | |
| Inspection at the NAL | C Health Benefit Plan offices in | Ashburn, Virginia. We | will contact you to arrange a time. | |
| Copy(ies) at the cost of these: | of 25 cents per page copied. The Priority Mail Certifi | e cost of postage will b ed Mail Exp | e added if you select one of ress Mail | |
| | ed health information (instead of e added if you select one of the Certified Mail | | cost not to exceed \$35. The cost of | |
| Signature of person re | equesting access to PHI | | Date | |