Part I - Request to Amend Personal Health Plan Information

Form Received By _____ Date _____

With certain exceptions, you have a right to request that the Plan amend your health information in a "Designated Record Set." The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete; was not created by the Plan (unless the person or entity that created the information is no longer available); is not part of the Designated Record Set; or would not be available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

1. Employee Name:	**1a. Employee Health Plan ID Number:**
1b. Employee Date of Birth:	
2. Name of Person Whose Records You Are Requesting:	**2a. Relationship to Employee** Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name:	**3a. Your Relationship to Person in Box 2** Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ **Other (please describe relationship):**
4. Mailing Address for Records:	**4a. City, State, Zip Code:**

I request that the Plan amend the following information in a personal health plan record [describe the information that is the subject of the Amendment request]:

_____

_____

_____

_____

The identified information should be amended because:

_____

_____

_____

I understand that if the Plan approves my request to amend a health plan record, the Plan will not necessarily delete the original information in the Designated Record Set, but instead may choose to identify the information in the Designated Record Set(s) that is the subject of my request for Amendment and provide a link to the location of the Amendment

_____ _____

Signature **Date**

Part II – Determination of Request to Amend Personal Health Plan Information

Form Part II Prepared By	Date Part II Issued

☐ Request Approved

☐ Request Denied for the following reasons [check all that apply]:

- ☐ The PHI or record was not created by the Plan.
- ☐ The PHI or record is not part of one of the Plan's Designated Record Sets.
- ☐ The PHI or record is not available for inspection under the HIPAA Privacy Rule.
- ☐ The PHI or record is accurate and complete referring.

If your request has been denied, you have the right to submit a statement of disagreement and the basis for such disagreement (limited to five (5) pages) to Human Resources – Benefits Department at 3715 Oakes Avenue, Everett, WA 98201. In response, Human Resources – Benefits Department will send you a copy of any rebuttal statement that is prepared. If you submit a statement of disagreement, when the Plan makes future disclosures of your disputed PHI or record, a copy of your request, the denial, and any disagreement and rebuttal will be attached to the disclosed PHI or record.

If your request has been denied and you choose not to submit a statement of disagreement, you may still ask the Plan to include a copy of your Amendment and the denial along with any future disclosures of the health information that is the subject of the Amendment request.

If you have been denied access to inspect and copy PHI, you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services according to the procedures at http://www.hhs.gov/ocr/hipaa2.html For more information, please contact Human Resources – Benefits Department at (425) 388-4710.

Name of Plan Representative	Signature of Plan Representative	Date of Determination

c. Restricted Access

Instructions for Responding to a Request for Restricted Use of PHI

Directions for the Plan's Administrator:

Providing Form. If any person wishes to request that the Plan restrict or terminate a restriction on the Plan's use and disclosure of his or her PHI, Restriction Contact should provide the person with this Form.

Receiving a Completed Form. Upon receipt of this Form, Restriction Contact must verify that Part I (Request for Restricted Use Personal Heath Plan Information) has been properly completed. To be properly completed, the appropriate boxes in each section must be marked, and the form must be signed and dated. If the person requesting the restricted use of PHI is not the subject of the PHI, Restrictions Contact should verify the identity and authority of the person and follow the procedures detailed in Section 3.03.

If Part I of the Form is incomplete, Restriction Contact should return it to the person for completion.

Determination of Request for Restricted Use of PHI. When Part I, Section A has been completed, Restriction Contact will respond by completing Part II (Determination of Request for Restricted Use of Personal Heath Plan Information), within the timeframes detailed in Section 5.04.

Terminating a Restriction. *Agreed Upon by a Participant (Part I, Section B).* When Part I, Section B, of the Form has been completed, Restriction Contact will not send a completed Part II (Determination of Request for Restricted Use of Personal Heath Plan Information), as detailed in Section 5.04.

Terminating a Restriction. *Not Agreed Upon by a Participant (Part III).* The Plan will only complete Part III of the Form to provide notice to a person (or the person's representative) that the Plan will terminate a previously agreed upon restriction, without the person's approval. The Plan will complete Part III on the original Form (where the restriction was requested and approved), as detailed in Section 5.04. Such restriction is effective only with respect to PHI created or received after the Plan has provided notice of the termination to the person.

Part I - Request for Restricted Use of Personal Health Plan Information

Form Received By _____ Date _____

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or Payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency Treatment, even if the Plan has agreed to a restriction.

1. Employee Name:	**1a. Employee Health Plan ID Number:**
1b. Employee Date of Birth:	
2. Name of Person Whose Records You Are Requesting:	**2a. Relationship to Employee** Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name:	**3a. Your Relationship to Person in Box 2** Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ **Other (please describe relationship):**
4. Mailing Address for Records:	**4a. City, State, Zip Code:**

ection A: Request to Restrict Use and Disclosure of Personal Heath Plan Information

request that the use and disclosure of personal health plan information for the person in Box 2 be restricted in the manner described below:

_____

_____

_____

understand that the Plan may deny this request. I also understand that the Plan may remove this restriction in the future if I am notified in advance.

ection B: Request to Terminate Restricted Use and Disclosure of Personal Heath Plan Information

☐ I request that the restriction on the use and disclosure of personal health plan information made on _____ [Date Initial Request Made] be terminated. I understand that upon receipt of this form, the Plan will terminate the previously accepted restriction. Once a restriction has been terminated, the Plan will use and disclose personal health plan information as permitted or required by law.

☐ I agreed orally to terminate the restricted use and disclosure of personal health plan information belonging to the person in Box 2 made on _____ [Date Initial Request Made]. This serves as formal documentation of that oral agreement.

_____ _____

ignature **Date**

Part II – Determination of Request for Restricted Use of Personal Health Plan Information

Form Part II Prepared By	Date Part II Issued

After reviewing your request to restrict use of personal health plan information, the Plan has made the following determination [check one of the following]:

☐ Request Approved

☐ Request Denied

Name of Plan Representative	Signature of Plan Representative	Date of Determination

Part III – Termination of a Request for Restricted Use of Personal Health Plan Information

Form Part III Prepared by	Date Part III Issued

The Plan is providing you with notice that it is terminating its agreement to restrict its use and disclosure of personal health plan information as documented above in Part II of this Form. Any personal health plan information created or received on or after _____ [Date of Mailing] will not be subject to the restriction. The Plan may use and disclose your personal health plan information as permitted by law.

Name of Plan Representative	Signature of Plan Representative	Date of Determination

d. Request for Confidential Communications

Instructions for Responding to a Request for Confidential Communications

Directions for the Plan's Adminsitrator:

Providing Form. If any person wishes to request that the Plan use an alternative means to communicate his or her personal health plan information or that he or she receive personal health plan information at an alternate location, Communication Contact should provide the person with this Form. Examples of alternative means could include mail instead of fax, phone instead of mail, etc.

Receiving a Completed Form. Upon receipt of this Form, Communication Contact must verify that Part I (Request for Confidential Communications of Personal Health Plan Information) has been properly completed. To be properly completed, the appropriate boxes in each section must be marked, and the form must be signed and dated. If the person requesting the Confidential Communications of personal health plan information is not the subject of the information, Restrictions Contact should verify the identity and authority of the person and follow the procedures detailed in Section 3.03.

If Part I of the Form is incomplete, Communication Contact should return it to the person for completion.

Determination of Request. Upon receipt of this Form with Part I properly completed, Communication Contact will respond by completing Part II (Determination of Request for Confidential Communications of Personal Health Plan Information), within the timeframes detailed in Section 5.05 of the Manual.

Part I - Request for Confidential Communications of Personal Health Plan Information

Form Received By _____ Date _____

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If the Payment of benefits is affected by this request, the Plan may also deny this request unless you contact the Communication Contact to discuss alternative Payment means.

1. Employee Name:	**1a. Employee Health Plan ID Number:**
1b. Employee Date of Birth:	
2. Name of Person Whose Records You Are Requesting:	**2a. Relationship to Employee:** Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name:	**3a. Your Relationship to Person in Box 2:** Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ **Other (please describe relationship):**
4. Mailing Address for Records:	**4a. City, State, Zip Code:**

I am requesting that communication of personal health plan information for the person in Box 2be provided by alternative means or at alternative locations. I [check one] ☐ am ☐ am not making this request because disclosure of all or part of the information to which the request pertains could endanger me, or the person I represent.

Please send the information by the following alternative means:

_____

_____

Please send the information to the following alternative address, if different than address above:

Street address _____

City, State and Zip code _____

Phone _____

Other _____

If this request relates to communication regarding Payment for health care services, please indicate how we can reach you to discuss alternative Payment means.

_____

Signature _____ **Date** _____

Part II – Determination of Request for Confidential Communications of Personal Health Plan Information

Form Part II Prepared By	Date Part II Issued

After reviewing your request for Confidential Communications of personal health plan information, the Plan has made the following determination [check one of the following]:

☐ Request Approved (see section A below)

☐ Request Denied (see section B below)

Section A: Request Approved

The Plan accepts your written request for the use of alternative means or alternative locations for Confidential Communications of personal health plan information The Plan will send personal health plan information [check all that apply]:

☐ By the alternative means you specified in Part I; and/or

☐ To the alternative address you specified in Part I.

Section B: Request Denied

The Plan denies your written request for the use of alternative means or alternative locations for Confidential Communications of personal health plan information for the following reasons [check all that apply]:

☐ The Plan has determined that the request is incomplete.

☐ The Plan has determined that the request is not reasonable

☐ The request does not clearly state that the Plan's usual means or locations of disclosure of personal health plan information poses a danger to you (or to the person in Box 2).

Name of Plan Representative	Signature of Plan Representative	Date of Determination

e. Accounting of Non-Routine Disclosures

Instructions for Responding for Accounting of Non-Routine Disclosures of PHI

Directions for the Plan's Administrator:

Providing Form. If any person wishes to request an accounting of non-routine PHI disclosures, Disclosure Contact should provide the person with this Form and a copy of the Privacy Notice detailing the non-routine disclosures.

Receiving a Completed Form. Upon receipt of this Form, Disclosure Contact must verify that Part I (Request for Accounting of Non-Routine Disclosures of Personal Health Plan Information) has been properly completed. To be properly completed, the appropriate boxes in each section must be marked, and the form must be signed and dated. If the person requesting personal health plan information is not the subject of the information, Disclosure Contact should verify the identity and authority of the person and follow the procedures detailed in Section 3.03.

If part I of the Form is incomplete, Disclosure Contact should return it to the person for completion.

Determination of Request. Upon receipt of the Form with Part I properly completed, Disclosure Contact will respond by completing Part II (Determination of Request for Accounting of Non-Routine Disclosures of Personal Health Plan Information), within the timeframes detailed in Section 5.06 of the Manual.

If the Plan is required to temporarily suspend a person's right to receive an accounting, as detailed in Section 5.06, Disclosure Contact must provide the person requesting the accounting with the appropriate information after the suspension of this person's right to receive the accounting has been lifted.