

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION



- This form authorizes VSP Global® (VSP®) to process your request for a copy of your records as contained in the VSP designated record set.
- Due to record retention schedule requirements, all records may not be available.
- Requests for records are generally completed within 30 calendar days; however, an extension may be requested.
- Records will be sent via U.S. Postal Service.
- You should make a copy of your signed request for your records before sending it to VSP.

Section 1 — Member Requesting Access to Protected Health Information			
First Name:	Middle Name/Initial:	Last Name:	
Address or PO Box:	City:	State:	Zip:
Member ID Number:	Social Security Number*:	Date of Birth (MM/DD/YYYY):	
Email (if Available):	Cell Phone Number:	Daytime Phone Number:	

*Member ID number OR Social Security number required.

Section 2 — Types of Records Requested
<input type="checkbox"/> Claims
<input type="checkbox"/> Complaints/appeals you have filed
<input type="checkbox"/> Authorization for Use and Disclosure forms you have submitted

Section 3 — I am requesting records for the following dates of coverage/service:	
From Date (mm/dd/yyyy):	From Date (mm/dd/yyyy):

Section 4 — (Optional) Please send my records to the person designated below:			
Name of Organization (if applicable):			
Name:	Phone Number:	Email Address:	
Address:	City:	State:	Zip:
Relationship to Member:			

Section 5 – Signature	
<p>I declare under penalty of perjury the information on this form or attached is true and correct. Any attempt to falsely gain access is subject to legal penalties.</p>	
Signature of Member or Personal Representative*	Date (mm/dd/yyyy)
Print Name of Personal Representative	
<p>*If this request is signed by a personal representative on behalf of the beneficiary, check the box that describes the relationship to the member, and attach documentation of authority (for example, power of attorney or guardianship).</p>	
<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Executor <input type="checkbox"/> Other	

VSP USE ONLY	
Status	Date Records/Notification Sent
<input type="checkbox"/> Requested records released	
<input type="checkbox"/> Missing signature	
<input type="checkbox"/> Missing dates of coverage/service	
<input type="checkbox"/> No records found	
<input type="checkbox"/> No supporting documents	
<input type="checkbox"/> Member not found	
<input type="checkbox"/> Other: _____	

Return completed form and any related documentation to VSP, Attn: Regulatory Compliance, 3333 Quality Drive MS-163 Rancho Cordova, CA 95670 or HIPAA@vsp.com