Guardian

# Request to Inspect & Copy Protected Health Information

You have the right to inspect and obtain a copy of most of your Protected Health Information (PHI) maintained in our possession. PHI routinely includes copies of your Claims and Explanation of Benefits (EOB's). In some instances, the PHI that we maintain may contain Medical Records. Enrollment information routinely includes copies of your Application for Coverage. In some instances, it may contain copies of requested Evidence of Insurability (EOI) and Medical Records.

You also have the right to request that we restrict the disclosure of your PHI.

If you request copies of your PHI, you will be charged a fee of a reasonable cost-based fee up to $25.00 to cover our administrative costs unless otherwise mandated by any applicable State law.

After we receive your request, we will contact you to notify you of the charge, if any, required to process your request.

**Member Information: (Individual whose information will be released)**

Name: ______________________________ Date of Birth: ____________________
(First, Middle, Last) (Month/Day/Year)

Address: ____________________________________________________________
City State Zip Code

Telephone Number (including area code): ______________________

Employer Name: ______________________________ Group Plan #: ____________________

Employee Name: ______________________ Last Four Digits of Social Security Number: ____________

Please indicate the **exact** health information you wish to review including the time period(s) (please indicate the coverages the information pertains to, i.e.: Dental, Vision).

______________________________________________________________

______________________________________________________________

______________________________________________________________

Do you want copies of your Original Enrollment information? ☐ Yes ☐ No. If "Yes", please specify exactly what Enrollment information you wish to review______________________________________

☐ Please restrict disclosure of my PHI for the purposes of Payment or Health Care Operations (but not Treatment).

We are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- The form is signed by your representative and the representative has not provided information on the source of their authority to act for you;
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of your records;
- Your request includes information compiled for litigation;
- Your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;
- A licensed health professional has determined that the requested access is likely to either endanger your or another person's life or safety or cause substantial harm to you or another person;
- Your request is to copy information and you are an inmate in a correctional facility;
- Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

Print Name: ______________________________ Relationship: ____________________

Signature: ______________________________ Date: ______________________

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Heath Care Power of Attorney).

☐ Please send my information to the following individual/entity:

Name: ______________________________ Relationship: ______________________

Address: ____________________________________________________________
City State Zip Code

Please send this form to: The Guardian Life Insurance Company of America
Employee Benefits Department, P.O. Box 981573, El Paso, TX 981573-79998-1573