Gold Coast Health Plan[SM]
A Public Entity

www.goldcoasthealthplan.org

Individual Request for Access to Personal Health Information

As provided by the Health Insurance Portability and Accountability Act (HIPAA), you have a right of access to inspect and obtain a copy of your health information contained in a Designated Record Set. This right does not apply to information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding.

Please indicate specifically the information to which you are requesting access:

Medical Claims Records for Date(s) ____

Medical Authorization Request Dates(s) ____

Care Management Records Date(s) ____

Pharmacy Claims Records Date(s) ____

Pharmacy Prior Authorization (PA) Request Date(s) ____

Notice of Action Date(s) ____

State Hearing Statement Date(s) ____

Other (please specify) ____

Gold Coast Health Plan (GCHP) will act on this request within 30 calendar days from the date GCHP receives this request or within 60 calendar days from the date GCHP receives the request if the requested information is not maintained or accessible to GCHP on-site. GCHP will either inform you of the acceptance of the request and provide you with the requested access or provide a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed. Please mail form to:

Gold Coast Health Plan
Attention: Office of Compliance
711 East Daily Drive, Suite 106
Camarillo, CA 93010-6082

or fax: 805-437-5132

Please indicate the form or format in which you would like to receive your requested information:

Paper   Electronic data file   Other ___________________________________

Please indicate the means by which you wish to inspect or obtain a copy of the requested information:

GCHP On-site Offices   Mailing Address ___________________________________   Other ___________________________________

If GCHP cannot readily produce the information in the form or format you have requested, such information will be made available to you in a readable hard copy form or other format agreed to. GCHP may impose a fee of $0.25 per page to cover the cost of copying your records.

Members Name ___________________________________

ID# ______________________________

Date of Birth ______/_____/______

Applicant Name ___________________________________

Relationship to Member ___________________________________

Applicant Signature ___________________________________

Date ___________/_____/_______

Tel. # ______________________

For GCHP Use

Received Date: ____________________________

Release Date: ____________________________

Staff Name: ____