



Request for Access to Protected Health Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Health Plan ID Number: _____

I hereby request a copy of my health information from NDPERS for the following dates:

I request the health information contained in the following records (please check all that apply):

- Enrollment
- Premium/contribution payment
- Administrative correspondence
- All of the above
- Other (please specify) _____

I understand that I may access my health information through any of the following methods (please check the desired method):

- I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to NDPERS by calling 701-328-3900 or 1-800-803-7377.
- I prefer to have the requested information copied and mailed to me at the following address.
- I prefer to receive a written summary of the requested information, instead of the complete records.

NDPERS has the right to assess you a reasonable cost-based fee for any of the above services. You will be informed in advance of the fee, if applicable.

_____/_____/_____
Signature of Requester Date

If signed by personal representative:

Name of personal representative (print): _____

Relationship to participant or nature of authority: _____

_____/_____/_____
Signature of Personal Representative Date