American Specialty Health

REQUEST TO KNOW/ACCESS CONSUMER HEALTH DATA

Please read this form carefully. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746 **Email:** HIPAA@ashn.com

Instructions for completion of this Form:

- **Member Information section** – provide all requested information.
- **Request Details section** – choose from the items available and/or write in information.
- **Acknowledgement & Signature section** – please sign, print your name, and date this form. If this request is being made by someone other than the member, you must complete the information below the Signature line, describe your authority to make this request on the member's behalf, and include copies of the supporting documentation.

MEMBER INFORMATION
Member Name:
Date of Birth:
Street Address[i]:
City:
State:
Zip:
Telephone:
Email[1]:

REQUEST DETAILS
I wish to exercise my Right to Know in relation to the following products (select all that apply): ☐ Active&Fit Direct ☐ Active&Fit (Active&Fit Enterprise)

[1] This information will be used to respond to your request. If different than the information linked to your account, please specify.

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☐ Active&Fit Now

☐ ChooseHealthy

☐ Other (specify _____)

For the last twelve months or this date range[2]_____:

☐ I hereby request American Specialty Health disclose the consumer health data it has about me.

☐ I hereby request American Specialty Health disclose third parties and affiliates with which my consumer health data has been shared.

ACKNOWLEDGEMENT & SIGNATURE

In signing this form, I understand that:

- American Specialty Health (ASH) will respond within 45 days of receiving this request.
- If ASH approves this request, ASH will mail or email the response to you using the information you provided above for email or address.
- Should ASH determine it is not able to fulfill your request ASH will respond in writing as to why. The denial will include any instructions on how to appeal.

Signature _____ Date of Signature_____
Printed Name_____

Relationship to Member: ☐ Self ☐ Other (complete the information below)

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation.

Name_____
Street Address_____
City_____State_____ZIP _____
Telephone_____

Description of Representative's Authority to Act/Relationship to Member (choose one):

☐ Member is a minor and I am the member's parent or legal guardian.

[2] The maximum time period would extend to 01/01/2020. If the time period is left blank, we will respond based off of the twelve months prior to the date of the request.

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☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).

☐ I am the member's agent, as designated in the member's Durable Power of Attorney (please attach necessary documentation).

☐ Other (please describe and attach necessary documentation):_____
_____

REQUEST TO KNOW CONSUMER HEALTH DATA CONTINUED

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