



PROTECTED HEALTH INFORMATION (PHI) REQUEST FORM

You may use this form to request a copy of your PHI or to authorize Start to share your information with another person.

If you need help completing the form, please contact our Start Health Assistants (PHAs) at 800-894-9454 or support@starthealth.com.

When Completed and signed please mail to: Start Health
 P.O. Box 7009718
 Sandy, UT 84070
 You may also email this form to
support@starthealth.com

Section I. The Member Access Request form is being requested for:			
Name of Member	Group ID #	Member ID #	
Social Security Number		Date of Birth	
Address	City	State	Zip Code
Telephone Number (XXX-XXX-XXXX)			

Section II. Please check the box for the records you wish to inspect or obtain a copy of and indicate date range:					
Enrollment Records	From:	To:	Health Records	From:	To:
<input type="checkbox"/> Application/Underwriting/ Attending Physician Statement Record (if applicable)			<input type="checkbox"/> Medical		
			<input type="checkbox"/> Dental		
<input type="checkbox"/> Premium Payment/Billing (if applicable)			<input type="checkbox"/> Prescription Drugs		
			<input type="checkbox"/> Vision		
			<input type="checkbox"/> Mental Health		
This Request CANNOT be used to disclose Psychotherapy Notes.					



Section III. Please choose which format you wish to receive/review your information.

Send my PHI to: (select only one)

Me

Designated Third Party: I request that Start send my PHI as specified in Section II above directly to the designated third party listed below.

Name	Address	City	State	ZIP	Phone Number
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Format/Manner: (select only one)

Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified. Email Address:

Send paper copy of information via US Mail.

View in person. I understand that I or my designee will be contacted to arrange for this.

Section IV. Signature- This document must be signed by the Member or the Member's Personal Representative.

I request that Start provide access to my PHI as specified. I understand that I can only sign on behalf of a minor child under the age of eighteen (18).

Signature

Date: month/day/year

Section V. If Section IV is signed by a Personal Representative, please complete the information below.

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, please attach a copy of the legal documents.

Personal Representative's Name	Relationship to Member
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Personal Representative's Address	City
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Personal Representative's Phone Number	Representative's Email
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Any changes to the form must be approved by the privacy officer.
support@starthealth.com

