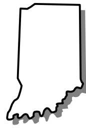
Indiana Health Coverage Programs



MEMBER ACCESS REQUEST

Section A: IHCP Member Requesting Access

Name: ______________________

Address: ______________________

City, State, ZIP Code: ______________________ Phone Number: ______________________

IHCP RID Number: ______________________ Social Security Number: ______________________

☐ Check this box, and complete the information below, if you want your health information records mailed to a different address.

Address: ______________________

City, State, ZIP Code: ______________________

Section B: To the member – Please read the following and complete the information requested

You have the right to inspect and obtain a copy of your health information maintained by the Indiana Health Coverage Programs (IHCP). You are not, however, entitled to inspect or copy information used for lawsuits, criminal investigations or prosecutions, notes made by a mental health therapist or psychiatrist, and certain other records. Please complete this form to request access to your health records maintained by the IHCP.

Specify the records, and the dates of the records to be inspected or copied: ______________________

I want to inspect these records. ☐ I want to obtain copies of these records. ☐

Do you want us to mail the copies? ☐

You may be charged a fee for the costs of copying, mailing, or for other supplies needed to fulfill your request. You will be notified of any costs prior to receiving the requested copies.

If you want us to provide copies of your records to any person other than your or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

Section C: To the member – Please sign the form and complete the appropriate information

Signature: ______________________ Date: ______________________

Section D: To the member's personal representative – Please sign the form and complete the appropriate information

If this request is from a personal representative on behalf of the IHCP member, please provide a copy of the documentation to support the representation and complete the following:

Personal Representative's Name: ______________________ Date: ______________________

Relationship to IHCP Member: ______________________

This form must be notarized if submitted by the member's personal representative.

Subscribed and sworn (affirmed) before me this ________ **day of** ______________________ , ________

Signature: ______________________

Notary Public in and for the state of ______________________

In the county of ______________________

(Affix seal) My commission expires: ______________________

Please mail this completed form to the following address:
IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260