

INDIVIDUAL REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

Insured's Full Name: _____ Policy No.: _____

Address: _____ DOB: _____

SSN: _____

As provided by the Health Insurance Portability and Accountability Act, you have a right of access to inspect and obtain a copy of your health information contained in a designated record set.

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

American Community Mutual Insurance Company will act on this request within 30 days of the date listed above or, within 60 days if the requested information is not maintained or accessible to American Community Mutual Insurance Company on-site. Such action 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.

If the requested information is contained in more than one designated record set or at more than one location, and access is granted, American Community Mutual Insurance Company needs only to provide you with access to information contained on one of the designated record sets.

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, on-site, etc.), and provide the necessary numbers or address:

Requested information will be made available to you in a readable hard copy form.

American Community Mutual Insurance Company will impose a fee schedule as follows: (a) Search Fee \$ 10.00; (b) Copies from paper .15¢ per page; (c) Copies from Microfilm/fiche .30¢ per page and (d) Postage.

Do you agree to such fees imposed by American Community Mutual Insurance Company. ___ Yes
___ No

Signature

Today's Date

FOR AMERICAN COMMUNITY USE: Date this request was received _____