REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI) MAINTAINED BY THE SCANA PHARMACY

Please provide the information below. We cannot respond to your request without this information.
Note: BCBSSC/ Caremark may require you to complete a separate form for information it maintains.

Patient's Name: ____
Last First Middle Date of Birth

Employee's Name:
(if not Individual) ____
Last First Middle Employee ID

Home Phone: ______________________

Home Address: ____

I hereby request that the SCANA Pharmacy provide me with my own copy of the PHI it maintains as checked below:

- ☐ Prescription medication records
- ☐ Payment records for prescription medication
- ☐ Claims adjudication record for prescription medication
- ☐ Patient information form

- ☐ I only want copy of PHI for the time period of: ______________ to ______________
  No access to PHI prior to April 14, 2003
- ☐ I would prefer to receive the Requested Information in the form of a summary prepared by the Pharmacy.

I understand that any information provided to me pursuant to this request will not include information compiled in reasonable anticipation of or use in legal proceedings, psychotherapy notes, clinical lab tests or lab results that fall under the Clinical Laboratory Improvements Amendments of 1988, 42 CFR 493.3(a)(2), or information the disclosure of which would violate the Federal Privacy Act.
I understand that the SCANA Health and Welfare Plan (Plan) may deny this request under limited circumstances as provided for under federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Plan who did not participate in the Plan's decision to deny my request.

I understand that the Plan will notify me of its decision to approve or deny my request to inspect or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at the Plan or within sixty (60) days if the Requested Information is not maintained or accessible on-site at the Plan. If the Plan is unable to comply with my approved request within the applicable time limit, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

Please provide the Requested Information to me in ☐electronic form or ☐paper form (check one).
I would prefer to ☐pick-up the PHI, ☐view the PHI at a mutually agreeable time and place, or ☐have the Requested Information mailed to the following address: ____

I understand that the Plan reserves the right to charge copying fees as well as any applicable postage. If I am granted access to the Requested Information, ☐would ☐would not like (check one) the Plan to provide me with an additional written explanation of such Requested Information.

______________________________ ______________________________
Signature of Individual (or Personal Representative)* **Date**

______________________________ ______________________________
Printed name of Personal Representative **Relationship to Individual**

* If the Request is signed by a personal representative, a signed and completed Personal Representative Form **must** be attached or on file with the SCANA Pharmacy, unless the Personal Representative Form is not applicable.

If you have questions about this form or your right to request, inspect or receive copies of your health information, contact the SCANA Pharmacy at **(803) 217-9173**.

FOR PLAN USE ONLY

Date Request Received: ______________ ☐ Approved ☐ Denied

Notice of extension sent: ______________ ☐ PHI prepared and delivered pursuant to above request.
Sent by: ______________ **Date:** ______________

*Completed request forms for Pharmacy-related records will be maintained by the SCANA Pharmacy.