State of Louisiana, Office of Group Benefits
Request for Access to Protected Health Information

I hereby request access to my protected health information for the purpose of inspection and/or obtaining copies:

Health Plan Member/Dependent Name: ______________________________

Date of birth: __________________

Address: ________________________________ **Telephone:** ______________

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Member Number: ______________________________

The documents requested are:

 Claims Remittance Records Correspondence

Other (specify) ____

The requested record dates are, or date range is:

Dates: ____

I understand that this request legally may be denied under certain limited circumstances but that, if it is denied, I will be advised in writing of the basis for the denial.

If my request for access is approved, I understand that I have the right to inspect the electronic version of these records at an OGB office. [Add details about logistics of inspection of electronic version, unless waived, plus logistics/cost of obtaining copies/faxes, summaries and explanations.]

Signed: ____________________________________ Date: ____________________
Signature of Health Plan Member/Dependent
or Personal Representative

Request Approved:

Records to be furnished for inspection and/or copying:

Signed: ______________________________________ Date: ________________________
Signature of Reviewer

Request Denied:

Reason:

Signed: ______________________________________ Date: ________________________
Signature of Reviewer