American Specialty Health

REQUEST TO KNOW PERSONAL INFORMATION (PI)

Please read this Request to Know form carefully and fill it out completely. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746; **Email:** HIPAA@ashn.com

Instructions for completion of this Form:

- **Member Information section** – provide all requested information concerning the member.
- **Request Details section** – choose from the items available and/or write in information if needed.
- **Acknowledgment & Signature section** – please sign, print your name, and date this form. If this request is being made by someone other than the member, you must complete the information below the Signature line, describe your authority to make this request on the member's behalf, and include copies of the supporting documentation.

MEMBER INFORMATION

Member Name:_____Date of Birth:_____
Street Address[1]:_____
City:_____State:_____Zip:_____
Telephone:_____Email[1]:_____

REQUEST DETAILS

I wish to exercise my Right to Know in relation to the following products (select all that apply):

- ☐ Active&Fit Direct
- ☐ Active&Fit
- ☐ ChooseHealthy
- ☐ Other (Specify_____)

☐ I hereby request American Specialty Health to disclose the categories of personal information it has about me.

☐ I hereby request American Specialty Health to disclose specific pieces of personal information it has about me.

American Specialty Health.

Acknowledgment & Signature

In signing this form, I understand that:

- American Specialty Health (ASH) will respond within 45 days of receiving this request.
- If ASH approves this request, ASH will mail or email the response to you using the information you provided above for email or address.
- ASH may deny this request in writing if ASH is unable to verify the request based on information provided, if the form is submitted incorrectly for processing, if the request is submitted more than twice in one calendar year (based on the date the earlier request was received), or if ASH requires the use of your information to provide services on your behalf or for any other acceptable business purpose.

Signature _____ **Date** _____
Printed Name_____
Relationship to Member: ☐ **Self** ☐ **Other (complete information below)**
If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation.

Name_____
Street Address_____
City_____**State**_____**ZIP** _____
Telephone_____

Description of Representative's Authority to Act/Relationship to Member (choose one):

- ☐ Member is a minor and I am the member's parent or legal guardian.
- ☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or
- ☐ I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).
- ☐ I am the member's agent, as designated in the member's Durable Power of Attorney (please attach necessary documentation).
- ☐ Other (please describe and attach necessary documentation):_____
  _____

1 This information will be used to respond to your request. If different than the information linked to your account, please specify.