**58771-****{stdMbrPERSLinkID}**

**Request for Access to Protected Health Information**



NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58771 (Rev. 01-2014)

**NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657**

**(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

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| PART A MEMBER INFORMATION | |
| Name (Last, First, Middle) {stdMbrFullNameLFM} | NDPERS Member ID {stdMbrPERSLinkID} |
| Last Four Digits of Social Security Number {stdMbrLastFourDigitsOfSSN} | Date of Birth {stdMbrDateOfBirth} |
| Health Plan ID Number | |
| **PART B MEMBER AUTHORIZATION & ACKNOWLEDGEMENT** | |
| I hereby request a copy of my health information from NDPERS for the following dates:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I request the health information contained in the following records (please check all that apply):  Enrollment  Premium/contribution payment  Administrative correspondence  All of the above  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I understand that I may access my health information through any of the following methods (please check the desired method):  I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to NDPERS by calling 701-328-3900 or 1-800-803-7377.  I prefer to have the requested information copied and mailed to my address on record.  I prefer to receive a written summary of the requested information, instead of the complete records. | |

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| NDPERS has the right to assess you a reasonable cost-based fee for any of the above services. You will be informed in advance of the fee, if applicable.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Requester Date of Request  If signed by personal representative:  Name of personal representative print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Relationship to participant or nature of authority:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  Signature of Personal Representative Date |