



**Privacy Request Form**

Date of Request: \_\_\_\_\_

**To request member information from Delaware Physicians Care (DPCI), please check one or more of the boxes below.**

- Receive copy of privacy practices.
- Receive claim records.
- Change something in member records.
- Receive list of organizations to whom DPCI gives out member records.
- Limit how DPCI uses and gives out member records.

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID #: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Are you the member?**  Yes  No **If "NO", tell DPCI who you are by checking one of the boxes below. Please give DPCI copies of papers that show you have the right to make this request.**

- I am the member's Dad/Mom or guardian.
- I make health care decisions for the member.
- The member has died, and I take care of his or her estate.
- Other (explain) \_\_\_\_\_

Name of Requestor (if not member): \_\_\_\_\_

**Please Explain Your Request**

Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. DPCI may charge you to receive copies of member records or a list of people and companies to which we give out member records. You need to tell DPCI if you can not pay any fee.

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**Where Do You Want The Records Sent**

Address: \_\_\_\_\_  
Street City, State Zip

**I (the member or person acting for the member) agree to the following:**

- I may authorize DPCI to use or give out member records. When I give an approval, DPCI will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to DPCI a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the DPCI's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell DPCI when and the reason I want it to end. Use the space below to explain:

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- I have read and understand this form.
- I am entitled to receive a copy of this form.

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If member - Signature of Member

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Date

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If member -Print Member Name

Please send this Privacy Request Form to:

**Delaware Physicians Care  
Privacy Officer  
252 Chapman Road Suite 250  
Newark, De 19702**

Call Delaware Physicians Care toll free at 1-866-543-2167 with questions or comments.

DPCI Revised: 10/09