Pekin Life Insurance Company
2505 Court Street • Pekin, IL 61558
ATTN: Diane Steiner – Privacy Officer
Phone: 800/322-0160, ext. 2393 • Fax: 309/346-8398

Request for Patient Access to Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than a health care provider.

I hereby request access to health information for:

_____

_____

(Print Patient's name and address)

If known: Year of birth: _____

SCOPE OF ACCESS REQUESTED

I would like access to:
- ❑ All the records ***or***
- ❑ The portion of the records concerning:

_____

_____

_____

_____

(Specify type of disease, accident, dates of treatment, or other portion of records in which you are interested.)

TYPE OF ACCESS REQUESTED

- ❑ Inspection. Please let me know when I may come to inspect the records, and the amount of the charge, if any. I understand that an employee of the Company may be present and that I may not make any marks or alter the records in any way.
- ❑ Copies. I would like copies of all records requested
- ❑ I would like the information in the following form or format:

_____

CHARGES

Inspection. I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $5.00 per quarter hour and I may be required to pay these costs before I may inspect the records.

Copies or Transfer. I understand that you may charge me a reasonable charge of up to $.25 per page for copies.

- ❑ I hereby agree to pay the charges specified above. Please bill me.
- ❑ Please call me to let me know the total cost that I will incur.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate:

Relationship:

parent or guardian of minor patient
guardian or conservator of an incompetent patient
beneficiary or personal representative of deceased patient
other (specify)

Name of Patient: _____