HEALTH TRADITION P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

# REQUEST YOUR HEALTH INFORMATION

To ask for a copy of your complete Health Tradition health record, fill out the **Request Your Health Information** form.

## INSTRUCTIONS FOR COMPLETION

1. Print or type.

2. Use blue or black ink.

3. **Participant/Subscriber's Name:** Whose health record do you want? Often, your name or your dependent's name.

4. **Participant/Subscriber's Number:** The subscriber number for this individual (person from #3).

5. **Requested Information:** What information do you want? Check all of the information you want.

6. **Requested Dates:** Do you want information for a specific date? Write "all records" to request all past records.

7. **Method of Receipt:** How do you want to receive your information?

8. **Participant/Subscriber's Signature:** The person's name on line #3 must sign the form.
- If a dependent is under 18, the parent/legal representative must sign the form.
- If an adult cannot sign the form, the parent/legal representative must sign the form and write why they are signing (disability or health condition).

9. **Date:** What date are you signing the form?

Send the completed form to:

**Address envelope:** Health Tradition
Attn.: Office of General Counsel
P.O. Box 21171
Eagan, MN 55121

**Or Fax:** (608) 781-9654, Attn.: Office of General Counsel

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1. Complete the form. Print or type. Use blue or black ink.

2. Send it to: **Health Tradition**
   **Attn.: Office of General Counsel**
   **P.O. Box 21171**
   **Eagan, MN 55121**

_____ _____
Participant/Subscriber Name Subscriber Number

**Requested Information:**

I would like a copy of my health information: *(check all requested information)

☐ Health ☐ Long Term Care ☐ Other _____

**Requested Dates:**

I want information from the following dates: _____

**Method of Receipt:**

I understand that I can receive my health information in different ways. If I ask for copies of my health information, I must pay a fee of $.20/page, if there are more than 30 pages. I must also pay for postage.

☐ Please copy my health information and send it to me at this address:

_____

_____

_____

☐ Please copy the information. I will pick up the copies. I understand that you will contact me when the copies are ready for pick-up.

☐ I want to look at my health information in person. I will call the Office of General Counsel [(608) 661-6632] to schedule a time.

☐ I do not want the complete record. Please write a summary of my health information. I understand that I must pay Health Tradition for the time it takes to prepare the summary.

_____ _____
Signature of Participant/Subscriber Date

**For Personal Representatives (Parents and Legal Representatives):**

_____ _____
Signature of Personal Representative Date

_____ _____
Printed Name of Personal Representative Relationship to Participant

*You must send proof of personal representative status with this form.