

**HEALTHPLUS OF MICHIGAN AND ITS SUBSIDIARIES  
MEMBER RECORDS AND RIGHTS REQUEST**

Subscriber Name:	
Subscriber Number:	
Member Number:	
Member Date of Birth:	
Relationship to Subscriber:	

- \_\_\_ Request for Member Records Copy and Release
- \_\_\_ Request for Confidential Communications or Restrictions on Disclosure of Member Records
- \_\_\_ Request for Restrictions on Use or Disclosure of Member Records
- \_\_\_ Request for Accounting of Disclosure of Member Records (not pursuant to treatment, payment, health care operations or a valid authorization).
- \_\_\_ Request for Amendment of Member Records

Dates of Request (Be Specific):

From \_\_\_\_\_ To \_\_\_\_\_ Date Needed By: \_\_\_\_\_

Reason for Request:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Send Information To: (For confidentiality reasons, information will only be sent to members.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***INCOMPLETE INFORMATION WILL RESULT IN A DELAY OF PROCESSING***

**By signing this Request for Member Rights, I hereby certify that the information provided above is true.**

\_\_\_\_\_  
Member's Signature (18 and over)

\_\_\_\_\_  
Signature of parent, guardian or other  
authorized representative of the member

Date Signed: \_\_\_\_\_

**PLEASE MAIL OR FAX THIS COMPLETED FORM TO:**

HealthPlus of Michigan  
P.O. Box 1700  
Flint, MI 48501-1700  
Attention: Legal Department  
Fax (810) 230-2197

Member Request is Denied Due to the Following Reason:

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