Equity-League Health Trust Fund (the “Plan”)
Request for Access to PHI

Name of Individual: ________________________________________
Date: _________________________
Union Membership Identification Number: ___________________________

I am requesting that I be allowed to inspect and copy the following PHI:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

I understand that I may be charged a fee for the costs of copying, including labor and supplies, and postage. I also may be charged the cost of preparing a summary of protected health information, if such a summary is requested. I have reviewed the Plan’s rules for access to information contained in the Plan’s Notice of Privacy Practices.

Signature of Individual Requesting Access to PHI: ______________________________

Signature of Personal Representative acting on behalf of the Individual, if the Individual is not making the request for access to PHI: