

### Request Form for Disclosure Report

By completing this form, you are requesting a report of disclosures of Protected Health Information that First Medical Health Plan Inc. has made for reasons unrelated to treatment, payment, health plan operations, and certain permitted activities, as described in the Notice of Privacy Practices.

You may submit your request by addressing it to **Chief Compliance and Privacy Officer of First Medical Health Plan, Inc.**, at **PO Box 191580, San Juan, PR 00919-1580**, by email at: [cumplimiento@firstmedicalpr.com](mailto:cumplimiento@firstmedicalpr.com), fax 787-300-3913 or by delivering it directly to any of First Medical Health Plan, Inc.'s Service Offices.

<b>I. Beneficiary/Subscriber Information:</b>		
Name:	Middle name:	Last Name:
Plan Identification Number/Contract Number:		Email:
Primary Phone:	<input type="checkbox"/> I authorize FMHP to send information to my email in a secure (Encrypted) manner	
Alternate Phone:		

<b>II. Notice to Applicant: Please read the following notice and provide the information requested.</b>
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You have the right to receive a report of the disclosures of your Protected Health Information that First Medical has made as part of its functions. The maximum reporting period is six (6) years prior to the date of your application, or as of April 14, 2003, whichever is shorter. The Law does not require inclusion of disclosures related to the following activities: (1) treatment, payment, or health care operations; (2) disclosures to you or your authorized representative; (3) as part of a limited set of data for purposes of research or public health activities; (4) national security or to intelligence agencies or correctional institutions relating to persons in custody; or (5) incidental to a permitted disclosure.

<b>III. Disclosure Report Requested</b>
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Specify the time period: From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
day/month/year      day/month/year

You are entitled to receive one free report every 12 months. Each additional report you requested within the same 12-month period will incur a per-page fee.

<b>IV. Please indicate how you would like to receive the requested report:</b>
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<input type="checkbox"/> Postal Mail	<input type="checkbox"/> Email	<input type="checkbox"/> Fax	<input type="checkbox"/> At hand
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<b>V. Signature</b>
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Beneficiary/Subscriber Signature	Date:
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If you are a Legal Representative of the Beneficiary/Subscriber, you must:

1. Indicate your full name: \_\_\_\_\_
2. Describe your authority to act for the Beneficiary/Subscriber (e.g., power of attorney, court order, or medical certification) \_\_\_\_\_

3. Provide a copy of the legal document that appoints you as Legal Representative. A Social Security proxy document is not admissible for purposes of this form (please request assistance from a Customer Service Representative).

Signature of the Legal Representative:

Date:

**For Exclusive Use of FMHP Only Compliance Department-Privacy Unit**

- Application Accepted  
 Application Denied Reason: \_\_\_\_\_  
 Beneficiary/Subscriber Notified Date: \_\_\_\_\_

If you need additional information, please contact First Medical Health Plan, Inc.'s Privacy Unit at 787-474-3999 extension 2108/2583. We are available Monday through Friday from 8:00 a.m. to 5:00 p.m.

The Customer Service Department offers free language interpreter services and sign language. This includes services in alternate formats such as Braille, large print, and translation to other languages, verbally or written, amongst others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

*El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor, comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.*

**First Medical** cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo. **First Medical** complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

First Medical 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。