Pacific Gas and Electric Company

Request for Access to Inspect and Copy Personal Health Plan Information

Form Received By	Date

With certain exceptions, you have the right to inspect or obtain a copy of your protected health information (PHI) in a "Designated Record Set" maintained by or on behalf of the following health plans sponsored by Pacific Gas and Electric Company: The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plan"). This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Health Plan uses to make decisions about individuals. You may request an electronic copy of your PHI if it is maintained in an electronic format and the form and format you request is reasonably accessible by the Health Plan. You may also request that a copy of your PHI be sent to another entity or person, so long as that request is clear, conspicuous and specific.

You do not have a right to inspect or obtain copies of psychotherapy notes or PHI compiled for civil, criminal, or administrative proceedings. In addition, the Health Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

The Health Plan may provide you with a summary or explanation of the PHI in your health plan records instead of access to or copies of your records, if you agree in advance and pay any applicable fees. The Health Plan may also charge reasonable fees for copies or postage.

1. Employee/Retiree Name	**1a. Employee/Retiree PERNO**
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Records You Are Requesting	**2a. Relationship to Employee/Retiree** ☐ Self ☐ Spouse ☐ Child ☐ Other
3. Your Name	**3a. Your Relationship to Person in Box 2** ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ **Other (please describe relationship):**
4. Mailing Address for Records	**4a. City, State, Zip Code**

Section A: Requested Personal Records.

Please identify the specific PHI in your health plan records you are requesting access to, including the time period to which the information relates:

Section B: Methods of Access.

I wish to inspect and copy the personal health plan information described in Section A using the following method(s):

- ☐ I wish to inspect the records requested in Section A in person. I will arrange a mutually agreeable time to come to the Health Plan by contacting the PG&E HIPAA Administrator.
- ☐ I wish to copy the records requested in Section A in person. I will arrange a mutually agreeable time to come to the Health Plan by contacting the PG&E HIPAA Administrator. I understand that I will be charged and I agree to pay the cost of copying at $0.25 per page or any part thereof, not to exceed $5.00.
- ☐ I wish to have copies of the records requested in Section A sent directly to me, at the address in Box 4. I understand that I will be charged and I agree to pay the cost of copying at $0.25 per page or any part thereof, not to exceed $5.00 plus postage.
- ☐ I wish to have electronic copies of the records requested in Section A that are kept electronically sent directly to me, at the address in Box 4. I understand that I will be charged and I agree to pay the associated cost.
- ☐ I wish to have copies of the records requested in Section A sent to the following person or entity:_______________________________, at the address in Box 4. I understand that I will be charged and I agree to pay the associated cost.
- ☐ I wish to have electronic copies of the records requested in Section A that are kept electronically sent to the following person or entity:_______________________________, at the address in Box 4. I understand that I will be charged and I agree to pay the associated cost.
- ☐ I wish to have the information requested in Section A summarized (instead of receiving the entire record) and sent to me at the address in Box 4. I understand that I will be charged for the summary provided and I agree to pay the cost of preparing the summary, any copying at $0.25 per page or any part thereof, not to exceed $5.00 plus postage.

Please return completed form to:

PG&E HIPAA Administrator
PG&E Benefits Department
245 Market Street, Mailcode N2T
San Francisco, CA 94105

______________________________________ ____________________

Signature **Date**