



Privacy Request Form

Date of Request: _____

To request member information from Schaller Anderson Medical Administrators, Incorporated (SAMAI-NH), please check one or more of the boxes below.

- Receive copy of privacy practices.
- Receive claim records.
- Change something in member records.
- Receive list of organizations to whom SAMAI-NH gives out member records.
- Limit how SAMAI-NH uses and gives out member records.

Recipient Name: _____

Date of Birth: _____

ID #: _____

Phone: (_____) _____

Are you the recipient? Yes No **If “NO”, tell SAMAI-NH who you are by checking one of the boxes below. Please give SAMAI-NH copies of papers that show you have the right to make this request.**

- I am the recipient’s Dad/Mom or guardian.
- I make health care decisions for the recipient.
- The recipient has died, and I take care of his or her estate.
- Other (explain) _____

Name of Requestor (if not recipient): _____

Please Explain Your Request

Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. SAMAI-NH Plan may charge you to receive copies of recipient records or a list of people and companies to which we give out recipient records. You need to tell SAMAI-NH if you can not pay any fee.

Where Do You Want The Records Sent

Address: _____
Street City, State Zip

I (the recipient or person acting for the recipient) agree to the following:

- I may authorize SAMAI-NH to use or give out recipient records. When I give an approval, SAMAI-NH will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to SAMAI-NH a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the SAMAI-NH's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell the Plan when and the reason I want it to end. Use the space below to explain:

- I have read and understand this form.
- I am entitled to receive a copy of this form.

If recipient - Signature of Recipient

Date

If recipient -Print Recipient Name

Please send this Privacy Request Form to:

Schaller Anderson Medical Administrators, Incorporated
Privacy Officer or Coordinator
53 Regional Drive
2nd Floor
Concord, NH 03301

Call SAMAI-NH at 1 (866) 499-9335 with questions or comments.

Revised: 10/09