HIPAA Privacy Form Instructions

HIPAA Privacy Form for:

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Salaried Employees

  and

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Hourly Employees

The above mentioned plans are referred to as the "Plan" on the form.

For definition of "Terms" refer to the Privacy Notice which can be viewed on the CITGO intranet or internet Web sites.

Note: Forms CANNOT be submitted electronically.
Forms must be printed and completed

Completed forms may be submitted via regular mail to:

CITGO Petroleum Corporation
Benefits Department: N5069
HIPAA Services Contact
P.O. Box 4689
Houston, Texas 77210-4689

or

Completed forms may be submitted via fax to 832-486-1842.

CITGO Petroleum Corporation
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 health information in a "Designated Record Set" maintained by the "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 Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

The Plan may provide you with a summary or explanation of the information 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 Plan may also charge reasonable fees for copies or postage. **Please print, complete and return this form by regular mail or fax.**

1. Employee/Retiree Name	1a. Employee/Retiree Health Plan ID Number or SSN
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Records You Are Requesting to Inspect and Copy	2a. Relationship to Employee/Retiree Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name (If not Employee/Retiree)	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 personal health plan information in your health plan records you are requesting access to, including the time period to which the information relates (attach additional pages if needed):

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 Plan by contacting the HIPAA Services Contact.

☐ I wish to copy the records requested in Section A in person. I will arrange a mutually agreeable time to come to the Plan by contacting the HIPAA Services Contact. I understand that I will be charged and I agree to pay the cost of copying at $1.00 per page, with a $5.00 minimum.

☐ 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 $1.00 per page, with a $ 5.00 minimum plus postage.

☐ 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 $1.00 per page, with a $5.00 minimum and postage.

Signature _____ Date _____