Exhibit A(1)

Commonwealth Health Insurance Connector Authority

Request Form to Inspect or Receive a Copy of PII

I understand that I have the right to inspect or receive a copy of my personally identifiable information (PII). I understand that there may be a fee for copies, preparation, or postage, and that I will be informed of an estimated fee in advance. I understand that my request to access my records may be subject to some limitations. I also understand that the Health Connector will acknowledge this request within 10 working days and respond to this request within 30 working days unless I receive notification in writing that it will take longer to process my request. I understand that I may designate another person or entity to receive the information I request.

Member name: _____
Date of Birth: _____
Address: _____
_____
Phone Number: _____
Email Address: _____
Member ID No.: _____
Date: _____

1. Identify what type of information you wish to see. **(Please contact your plan or provider for any claims or other health information that does not relate to your eligibility for Health Connector programs or your enrollment, as the Heath Connector does not maintain that information.)**

   _____
   _____

2. I would like the information to be provided as follows:
   - _____ Electronic copy sent to the email address above.
   - _____ Copy to be mailed to my address.
   - _____ Other: Please specify:

_____

3. **Optional**: I would like the information to be sent

_____ To another person or entity as well as to me

_____ Only to another person or entity

Contact information for other person or entity to receive the requested information:

Address: _____

_____

Phone Number: _____

Email Address: _____

Requester's Signature: _____

Date: _____

Mail to: Compliance Manager
Commonwealth Health Insurance
Connector Authority
P.O. Box 960484
Boston, MA 02196

THE FOLLOWING INFORMATION IS NEEDED IF THE REQUESTER IS A PERSONAL REPRESENTATIVE

Print Name: _____

Type of authority (e.g., court-appointed) _____

Health Connector Office Use Only:

Date Request Received by the Connector_____

___ Request Denied ___Approved as Requested

Requester Informed via Response Form: Yes ___ Date _____

Exhibit A(2)

Commonwealth Health Insurance Connector Authority

Response to Request for Access to PII

To:_____

_____

_____

☐ ***Need for Extension of Time***

The Health Connector received your request to access health information on _____. The Health Connector has evaluated your request to access health information. A delay in providing the information is necessary for the following reason(s):

_____

_____

The Health Connector will respond to your request by _____ [no later than 60 days from the date of the request].

☐ ***Denial***

Your request is denied for the following reason:

☐ You requested claims or other health information, but the Health Connector has does not have such claims or health information about you. **Please contact your provider(s) and/or your health plan to request access to this information.**

☐ Other:_____

_____

_____

_____

☐ ***Grant***

Your request for access to your protected health information has been granted.

☐ A copy of your protected health information held by the Health Connector is enclosed.

☐ A copy of your protected health information will be provided by the following means:

_____
_____
_____

☐ We will provide you with a copy of your protected health information but there is a copying and compiling fee of $_____ for the records. Please send a send a check or money order payable to the Commonwealth Health Insurance Connector Authority, P.O. Box 960484, Boston MA 02196. Upon receipt we will provide you with the copy of your information.

If you have any questions, please call 617-933-3095. Thank you for letting us be your connection to good health.

You have the right to appeal this decision. Please refer to the Health Connector's Policy and Procedures for the Protection of Member Privacy Rights for instructions on how to submit an appeal. You have 30 calendar days from the date of this notice to submit an appeal. Appeal requests submitted more than 30 calendar days from the date of this notice will be dismissed without further review.

Sincerely,

COMPLIANCE MANAGER

Dated:

EXHIBIT B(1)

Commonwealth Health Insurance Connector Authority

REQUEST TO CORRECT PII

I request that the Health Connector correct my personally identifiable information (PII) as follows:

_____
_____
_____
_____
_____

My reason for the request is:

_____
_____
_____
_____
_____

If the correction request is approved, I want the Health Connector to provide the corrected information to the following people. (Please include addresses and contact information for these people.)

_____
_____
_____

I understand that the Health Connector will make reasonable efforts to inform these individuals and other persons that the Health Connector knows may have relied on or could rely on the information of the amendment within a reasonable time.

I understand that if the protected health information was not created by the Health Connector, the Health Connector is not required to allow my request.

Signature: _____
Member name: _____
Date of Birth: _____
Address: _____
_____
Phone Number: _____
Email Address: _____
Member ID No.: _____
Date: _____

Mail to: Compliance Manager
Commonwealth Health Insurance
Connector Authority
P.O. Box 960484
Boston, MA 02196

Health Connector Office Use Only:

Date Request Received by the Connector_____

___ Request Denied ___Approved as Requested

Requester Informed via Response Form: Yes ___ Date _____

Exhibit B(2)

Commonwealth Health Insurance Connector Authority

Response to Request to Correct PII

To: _____

_____

_____

The Health Connector received your request to correct PII on _____.

___ ***Need for Extension of Time***

___ ***Denial***

Your request for correction was denied for the following reasons:

_____

_____

_____

_____

_____

___ ***Grant***

Your request for correction was allowed.

You have the right to appeal this decision. Please refer to the Health Connector's Policy and Procedures for the Protection of Member Privacy Rights for instructions on how to submit an appeal. You have 30 calendar days from the date of this notice to submit an appeal. Appeal

requests submitted more than 30 calendar days from the date of this notice will be dismissed without further review.

Sincerely,

COMPLIANCE MANAGER

Dated:

EXHIBIT C(1)

COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

REQUEST TO RESTRICT COLLECTION, USE, OR DISCLOSURE OF PERSONAL INFORMATION

I request that the Health Connector restrict the collection, use and disclosure of my personally identifiable information (PII) as mentioned below. I understand that the Health Connector is not required to agree to my request for restriction, and in some cases the restriction may not be permitted under law. I understand that if the request is agreed to, the Health Connector will be bound by the agreement unless the information is needed to provide me with emergency treatment or to comply with the law.

Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

(1) I request the following information be restricted [description of information]:

_____

(2) I request that collection, use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

(3) I request that my PII not be disclosed to the following individuals or entities [list of individuals or entities to which information would not be disclosed]:

_____

Health Connector Required to Grant Certain Requests

The Health Connector must grant my request to restrict PII collection/use/disclosure if

- The PII pertains solely to a health care item or service for which the Health Connector has been paid in full.

Health Connector Not Otherwise Required to Agree

I understand that the Health Connector is not required to agree to this request for restriction of collection/use/disclosure, including such collection/use/disclosure that is:

- Required by law;
- Required by a court order;
- Disclosed to a health oversight agency for oversight purposes;
- For certain law enforcement purposes and certain specialized government functions;
- Required for certain research purposes; or
- Required to give me emergency treatment.

Termination of Restriction

I understand that if the Health Connector agrees to this restriction, either the Health Connector or I may terminate this restriction at any time, unless such restriction is of the kind the Health Connector must grant, in which case only I may terminate it. Any termination of the restriction is only effective for **future** uses and disclosures.

Signature of Enrollee/Personal Representative _____

Date _____ Print Name: _____

Personal representatives:

I am authorized to make medical decisions for the enrollee based upon court order____

Custodial parent ____ Other_____ :

Mail to: Compliance Manager
Commonwealth Health Insurance
Connector Authority
P.O. Box 960484
Boston, MA 02196

Health Connector Office Use Only:

Date Request Received by the Connector_____

___ Request Denied ___Approved as Requested

Requester Informed via Response Form: Yes ___ Date _____

EXHIBIT C(2)

Commonwealth Health Insurance Connector Authority

Response to Restriction Request

To:_____ Date:_____

_____

_____

The Health Connector has received your request to restrict use and/or disclosure of your Personally Identifiable Information (PII).

____ Your request is approved. Please refer to the request form for a list of circumstances when the Health Connector may have to use/or disclose your PII despite the restriction.

____ Your request is partially granted.
Specifically:_____
_____
_____
_____

___ Your request is denied for the following reasons:
_____
_____
_____
_____

You have the right to appeal this decision. Please refer to the Health Connector's Policy and Procedures for the Protection of Member Privacy Rights for instructions on how to submit an appeal. You have 30 calendar days from the date of this notice to submit an appeal. Appeal

requests submitted more than 30 calendar days from the date of this notice will be dismissed without further review.

Sincerely,

COMPLIANCE MANAGER

Dated:

EXHIBIT D(1)

COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

APPEAL OF PRIVACY RIGHTS DETERMINATION

I request an appeal of the following privacy rights determination issued by the Health Connector related to Personally Identifiable Information (PII) the Health Connector maintains in its electronic eligibility determination, enrollment, and premium billing systems:

☐ **Access**

☐ **Correction**

☐ **Restriction to Use**

Date of privacy rights determination being appealed: _____

In the space below, describe the reason you are appealing the determination, and what your requested remedy is:

_____
_____
_____
_____
_____
_____

Your appeal will be reviewed in accordance with the standards described in the Health Connector's Policy and Procedures for the Protection of Member Privacy Rights, per the respective right at issue. The Health Connector will resolve your appeal within 30 working days of its receipt of your appeal request and notify you of the outcome in writing. If the Health Connector requires additional time, it will provide you written notice of the need for additional time, which will not be more than 30 additional working days.

Signature: _____
Member name: _____
Date of Birth: _____
Address: _____
_____
Phone Number: _____
Email Address: _____
Member ID No.: _____
Date: _____

Mail to: Privacy Officer
Commonwealth Health Insurance
Connector Authority
P.O. Box 960484
Boston, MA 02196

THE FOLLOWING INFORMATION IS NEEDED IF THE REQUESTER IS A PERSONAL REPRESENTATIVE
Print Name: _____
Type of authority (e.g., court-appointed) _____

Health Connector Office Use Only:

Date Appeal Request Received by the Connector_____

___ Appeal Request Denied ___ Appeal Approved as Requested

Date Requester Informed via Response Form: _____

EXHIBIT D(2)

COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

FINAL DECISION REGARDING APPEAL OF PRIVACY RIGHTS DETERMINATION

To: _____

_____

_____

The Health Connector received your appeal request to regarding [ACCESS TO/CORRECTION TO/RESTRICITON TO USE] PII on _____.

☐ **Need for Extension of Time**

The Health Connector requires additional time to review your appeal request, for the following reason(s):

_____

_____

The Health Connector will respond to your request by _____ [no later than 30 working days from the date of your appeal].

☐ **Appeal Approved**

The Health Connector has approved your appeal will take the following action:

_____

_____

_____

_____

_____

☐ **Appeal Denied**

The Health Connector has denied your appeal for the following reason(s):

_____
_____
_____
_____
_____

This appeal decision is final and is not subject to further review.

Sincerely,

PRIVACY OFFICER

Dated: