Tribute
Health Plans

Complete
Personal and Direct Care

Request for Accessing Health Information

Participant Information:		
First Name:	Last Name:	Middle Initial:
Member ID Number or MBI:	Date of Birth:	Phone Number:

Request to Access/Inspect/Copy:

I am requesting my health information in the following designated record set(s) for the period of time from

____________________ to ________________________

☐ Enrollment, payment, and/or claims adjudication maintained by ASSI
☐ Other records maintained by ASSI: ____

Delivery Method:

☐ Mail to this address: ____
Street address City State Zip

☐ Pick-up or review in person (you will be required to provide photo identification.) Please provide a phone number where we may contact you to schedule an appointment: ____________________________

Acknowledgement:

Please sign and date: I understand that I may be charged a reasonable cost-based fee for copying my records. Applicable mailing fees also may apply. With certain exceptions, you have the right to inspect or obtain a copy of your health information in a designated record set maintained by Arkansas Superior Select.

My Signature or my Legal Representative's Signature: Date:

____ ____________________

Printed Name: ___________________________________

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative, etc.): ____

Mail signed Authorization Form to: Tribute, PO Box 3630, Little Rock, AR 72202