Request for Access to Records (Records Request)

The purpose of this form is to request copies of your records. Please complete this form and send it to the following address:

TMG
2424 Rimrock Road, Suite 230
Fitchburg, WI 53713
Fax: 1-608-255-0898

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1. PARTICIPANT INFORMATION (PLEASE PRINT)

Name _____ Date of Birth: _____

Address: _____ Phone: _____

☐ Check this box if you want your records mailed to a different address. If so, complete the information below:

Address – Street, City, State, Zip Code _____

If you want to provide copies of your records to any person *other than you or your guardian or legal representative*, you must also complete and send a signed *Release of Information* form.

2. RECORDS REQUEST / ACCESS REQUEST

Specify *which records* you want to review or have copied and sent to you:

☐ _____

☐ Long Term Care Functional Screen (LTC-FS)

Specify the *timeframe* of the records you want to review or have copied and sent to you:

☐ Specify year(s):_____

☐ LTCFS – specify year(s): _____

Specify *how* you want to access the records

☐ I want a copy of my records mailed to me

☐ I want a copy of my records emailed to me (Email address: _____)
I understand that I will receive these records in an encrypted format.

☐ I want to review my records at TMG's office.

☐ I need to have an interpreter present to review the records with me at TMG's office.

☐ Language _____

3. SIGNATURES

Printed Name (Participant) _____

Signature (Participant) _____ Date Signed: _____

☐ *This request is made by an individual, other than the participant, legally authorized to make the request on behalf of the participant.*

Printed Name (Legal Representative) _____

Relationship to Participant _____

Legal Authority

Signature (Legal Representative) _____ Date Signed: _____

4. OTHER IMPORTANT INFORMATION

A. I understand I have the right to request my IRIS record, including records used to make decisions about my services. This request may not apply when the information I am requesting is not subject to right to access.

B. I understand if this request is granted, in whole or in part, I will be provided with a copy of my records or will review my records at the TMG office.

C. I understand TMG has 10 business days upon receipt of this form to respond to this request. If the records request cannot be completed within that time, I will be contacted with the reason for the delay and the date by which the request will be completed. *If this request is related to a hearing*, I will be provided with a copy of the records within a reasonable time before the hearing.

D. Contact information for questions, concerns, or further information:

QUALITY SERVICES
844-864-8987
Business hours are 8:00 a.m. to 4:30 p.m.

Mailing Address:
TMG
1 South Pinckney Street, Suite 320
Madison, WI 53703
tmgicaoperations@tmgwisconsin.com

The Management Group (TMG) administers certain Medicaid programs under contract with the Wisconsin Department of Health Services (DHS). As part of our contract, the Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require us to have processes that give you certain rights regarding your confidential information. You have the right to review or obtain copies of your records containing personal information, such as enrollment, services, or other records used to make decisions about your services. For more information about your privacy rights, please review the *Notice of Privacy Practices* on the DHS website: http://www.dhs.wisconsin.gov/publications/p1/p13040.pdf.