

Mphasis Employee Health and Welfare Benefit Plan

REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

Name: _____

SSNO: _____

I hereby request to review "Protected Health Information" ("PHI") maintained about me by the (Mphasis Corporation) Employee Health and Welfare Benefit Plan (the "Plan"), pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Please Check The Appropriate Box Below:

_____ I want to inspect PHI that is maintained about me under the Plan.

_____ I want to obtain a copy of PHI that is maintained about me under the Plan.

_____ I request that a copy of PHI that is maintained about me under the Plan be mailed to the following person/organization:

Name: _____

Address: _____

By your signature below, you signify your assent to the following:

- The Plan has 30 days to respond to this request, or 60 days if someone else holds the information or the information is off-site. If additional time is necessary, the Plan may extend these periods for an additional 30 days provided I am given written notice of the extension, prior to the expiration of the initial period, including the reason for the delay.
- If I am requesting to inspect PHI, the Plan will contact me to arrange a mutually convenient time and place for such inspection.
- The Plan has the right to charge a reasonable fee for copying, summarizing or explaining my PHI.
- I understand that this request does not apply to the following information: 1) information not held within a designated record set; 2) psychotherapy notes; 3) information compiled in reasonable expectation of, or for use in, a civil, criminal, or administrative action or proceeding; and 4) other health information not subject to the right to access information under HIPAA.

Date

Signature of Participant