

Plan Member Request for Accounting of Disclosures of Protected Health Information

Member Name (PLEASE PRINT): _____ SSN: _____

Mailing Address: Street _____

City _____ State _____ Zip _____

Complete This Section

I request an accounting of disclosures by the Plan of my group health plan Protected Health Information (PHI) during the following time period:

Begin Date _____ to End Date _____.

The begin date is no earlier than the Privacy Standards implementation date of April 14, 2003. I understand that the Plan may need assistance of its Business Associates in responding to this request.

Important Information About Your Request

I understand that an accounting in response to my request need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to me; (c) incident to a use or disclosure otherwise permitted or required by the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"); (d) pursuant to an authorization; (e) to certain persons involved in my care or payment for that care; (f) to notify certain persons of my location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003.

I understand that the accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of this request, including disclosures to or by Business Associates of the Plan.

I understand that the Plan has 60 days to respond to this request. If the Plan is unable to take action within that time period, the Plan may extend the time by 30 days. The Plan will notify me within the initial 60-day time period in writing of the reasons for the delay and the date by which the Plan will complete its action on the request.

If this request is for a second or subsequent accounting within a 12-month period, I agree to pay any fees for the accounting. Fees will be reasonable and cost-based.

Date _____ Signature _____

Please mail to:

Benefit Services Manager
Department of Human Resource Services
Benefit Services Division
2033 K Street, NW, Suite 220
Washington, DC 20052

For Plan Use Only: Date Request Received _____
By: _____