



## ACCOUNTING OF DISCLOSURE REQUEST

Purpose: This form is used to document an individual's request for an accounting of disclosures of protected health information.

### **SECTION A: Individual requesting disclosure accounting.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Member Identification Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### **SECTION B: To the Individual—Please read the following.**

You have the right to an accounting of the disclosures that we or our business associates have made of your protected health information. The accounting period is the 6 years prior to your request, except you are not entitled to an accounting of any disclosures made before April 14, 2003, which is our compliance date under the federal privacy rules. You are also not entitled to an accounting for disclosures we or our business associates made to carry out our payment or our health care operations activities, for which you gave us authorization, made to you or to your personal representatives, made for national security or intelligence purposes, or made to certain law enforcement agencies.

You are entitled to one free disclosure accounting each 12 months. We will charge you \$25.00 for each additional disclosure accounting you request during the same 12-month period.

To request a disclosure accounting, please complete the information below.

### **SIGNATURE**

I request an accounting of the accountable disclosures of my protected health information made since \_\_\_/\_\_\_/\_\_\_ (except not earlier than 4/14/03, the compliance date under the federal privacy rules and not more than 6 years from the date of this request). I understand that I am entitled to one free disclosure accounting each 12 months. I agree to pay \$25.00 for this disclosure accounting if I have already received a disclosure accounting from you within the previous 12 months.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS REQUEST.**

**Univera Community Health  
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