

# Individual Request for Accounting of Disclosures

**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**

Covered Employee's Name: \_\_\_\_\_ Employee's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Covered Employee's Employer: \_\_\_\_\_ Current Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Name of Individual Making Request: \_\_\_\_\_ Individual's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Current Address: \_\_\_\_\_

## **SECTION B: To the Individual – Please read the following**

You have the right to an accounting of certain disclosures 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 the date the HIPAA Privacy compliance date for your health plan, 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 your treatment, payment for that treatment or our health care operations, made to you or to your personal representatives, made to your family, close friends and others involved in your health care, 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. Subsequent requests for any 12-month period can be provided for a charge of \$50 for each period. Example: if the request is for a 48-month period (4 years), the charge would be zero for the first 12 months, and \$150 for the three additional 12-month periods. You are also entitled to receive a copy of this request.

To request a disclosure accounting, please complete the signature block in Section C.

## **SECTION C: Signatures**

I request an accounting of the accountable disclosures of my protected health information made within the 6 years prior the date of this request (except no earlier than your compliance date under the federal privacy rules). I understand that I am entitled to one free disclosure accounting each 12 months. I agree to pay \$25 for this disclosure accounting if I have already received a disclosure accounting from you within the previous 12 months.

\_\_\_\_\_  
Patient's Printed Name Date

\_\_\_\_\_  
Patient's signature Date

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

\_\_\_\_\_  
Patient Representative's Printed Name Date

\_\_\_\_\_  
Patient Representative's Signature Date

\_\_\_\_\_  
Relationship of Representative to Individual

Please submit this request to HealthSCOPE Benefits at any of the following addresses:

HIPAA Official  
P.O. Box 1224  
Little Rock, AR 72203  
or  
Customer Service – HIPAA  
PO Box 16526  
Columbus, Ohio 43216  
or  
Customer Service – HIPAA  
PO Box 50440  
Indianapolis, IN 46250