REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTEDHEALTH INFORMATION (PHI) FORM

Name of Individual: ______________________________ **Date of request**_________

Address: _______________________________________
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Telephone: ____________________________________

Member ID Number: ___________________________

I request an accounting of disclosures of my protected health information made by Wellplace to include disclosures made from _______________ to ____________.

I understand that Wellplace has 60 days to comply with this request. Wellplace may extend this time period by an additional 30 days if I am provided with the reasons for the delay within the initial 60 day time period.

The accounting I receive will NOT contain disclosures:

- To carry out Treatment, Payment, or Healthcare Operations;
- Pursuant to my authorization;
- Made to me;
- For the facility's directory
- To persons involved in my care or other notification purposes;
- Incidental to a permissible use or disclosure;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officials;
- As part of a limited data set;
- De-identified data; or

Signature of Individual: _____________________________________

Printed Name: ____