DISCLOSURE ACCOUNTING REQUEST
(Health Plan)

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: ____________________________ Identification Number: __________________

SECTION B: To the individual—Please read the following.

You have the right to an accounting of certain disclosures that we or our business associates have made of your protected health information. The maximum accounting period is the six (6) years prior to your request, except you are not entitled to an accounting of any disclosures made before April 14, 2003. We also do not have to account for disclosures we or our business associates make (a) for purposes of your treatment, to obtain payment or for health care operations (including certain disclosures for the payment or operations of others); (b) to you or to your personal representative or pursuant to your authorization or informal agreement; (c) as part of a limited data set; (d) made incidental to an allowable disclosure; or (e) for national security or intelligence purposes, or to certain law enforcement agencies.

You are entitled to one free disclosure accounting each 12 months. You will be charged $.50 per copied page for each additional disclosure accounting you request during the same 12-month period. Our Business Associates may charge a different and separate amount for their accounting of disclosures.

To request a disclosure accounting, please complete the signature block below.

INDIVIDUAL'S SIGNATURE.

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

PLEASE RETURN THIS FORM TO:

PRIVACY COORDINATOR
Planned Administrators, Inc.
PO Box 6927
Columbia, SC 29260