Request for Accounting of Plan's Disclosures of Protected Health Information (PHI)

Complete the following chart with information about the person whose PHI is subject to this request.

Name (Last, First, MI):	
Address (City,State,Zip):	
Phone:	
Date of Birth:	

If you are not the employee, complete the following:

Employee Name:	
Employee ID #:	
Employee Date of Birth:	

I am requesting that I be provided an accounting of the disclosures of the following PHI for the above noted individual during the time period starting_____ and ending_____. I understand that the accounting will not include disclosures for which an accounting is not required under the HIPAA privacy rules. I also understand that where the Plan provides an accounting to me, it will provide it once free of charge within a (12) month period. Any additional request for an accounting within the twelve (12) month period will be subject to a reasonable cost based fee.

State the specific PHI that is being requested:

If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this request. *(A personal representative may be requested to provide verification of representative status.)*

_____ _____
Signature of applicant or personal representative Date

Relationship of personal representative to member: _____

Send completed form to: **Privacy Official**
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251
Phone: (480) 312-7600
FAX: (480) 312-7960

Request approved ☐
Extension needed ☐ Reason: _____
Date information will be provided: _____
Request denied ☐ Reason for denial_____

By: _____ _____ _____
COS Signature Date Name and Title