Information About Your Request for an Accounting of Disclosures

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What does the right to an accounting of disclosures mean?

You may ask for a list of the times over the past six years when we shared your protected health information (PHI) with another person or organization. This includes the times we share your PHI outside of our normal business practices and outside of disclosures allowed by law.

What do I need to understand to use this right?

The list will not include the times when such information:

- Was shared with you or your personal representative.
- Was shared with your authorization.
- Was shared for your treatment.
- Was shared to pay for your health care.
- Was shared for our health care operations.
- Was shared for national security or intelligence purposes.
- Was shared with correctional institutions or law enforcement.
- Was shared as part of a limited data set for research or public health activities.

Community Health Plan will respond to this request within 60 days. If the Plan cannot respond within 60 days, we will send you a written notice that it will take longer.

How much will this cost me?

If you ask for a list more often than once every 12 months, we may charge you a fee for copying and mailing. When a fee applies, we will tell you how much it will be so that you can decide if you want to change or cancel your request.

How do I make a request?

Complete and print the attached form, then mail it to the address printed at the end of the form.

How will I know if my request is processed?

We will send a letter to the address you write on the form. The letter will tell you whether we approved or denied your request.

How can I get a full notice of my privacy rights?

A full notice of your privacy rights is posted to the Community Health Plan web site at:

http://www.chpw.org/en/member/docs/2010_NOPP.pdf

You may also request a copy by calling the Community Health Plan customer service team at 1-800-440-1561. If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free).

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

COMMUNITY HEALTH PLAN of Washington

Section A: Member Information

Member Name: ______________________ Date of Birth: ______________________

Member ID #: ______________________ Date of Request: ______________________

Address: ____

City: ______________________ State: ______ Zip Code: ______________

Phone: ______________________ Fax: ______________________

Choose One:

☐ OK to leave message with detailed information ☐ Leave message with call back number only

Section B: Details of the Request

Request for an Accounting of Disclosures of Protected Health Information

For the time period below, please provide me with a list of the times you shared my protected health information, above and beyond the disclosures allowed by law:

From: Month: ______________________ Year: ______________________

To: Month: ______________________ Year: ______________________

Section C: Signature and Date

Member or Representative Name: ____

Member or Representative Signature: ______________________ Date Signed: ______________

Please complete the form and return a copy to:

Community Health Plan
Attention: Privacy Officer
720 Olive Way, Suite 300
Seattle, WA 98101

Please type or print neatly. We will not process incomplete or illegible forms.