STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
REQUEST FOR ACCOUNTING OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request an accounting of disclosures of my protected health information (PHI) by or on behalf of the Office of Group Benefits.

MEMBER/DEPENDENT NAME	DATE OF BIRTH	MEMBER ID NUMBER OR LAST 4 DIGITS OF SSN	
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS	TELEPHONE (PRIMARY)	TELEPHONE (ALTERNATE)	
TIME PERIOD OF DISCLOSURES TO BE ACCOUNTED FOR (MAY NOT EXCEED SIX(6) YEARS FROM THE DATE OF REQUEST)			

I understand that I am entitled to one accounting of disclosures during a twelve (12) month period at no charge. I also understand that if OGB has provided me with an accounting of disclosures within the previous twelve (12) months, OGB may charge me a reasonable fee for providing this accounting.

I also understand that many disclosures (e.g., for purposes of treatment, payment, or health care operations) are not required to be, and will not be, included in the accounting.

SIGNATURE OF HEALTH PLAN MEMBER/DEPENDENT OR REPRESENTATIVE

DATE

This form may be sent by mail or fax to:

Office of Group Benefits
Medical/Pharmacy Section
P.O. Box 44036
Baton Rouge, LA 70804
Fax: (225) 342-9917