STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
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:

Health Plan Member/Dependent Name: ______________________________

Date of Birth: ______________________________

Member ID number: ______________________________

Address: ______________________________

Telephone: ______________________________
(primary number) *(alternate number)*

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 the OGB has provided me with an accounting of disclosures within the previous twelve (12) months, the 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.

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Signature of Health Plan Member/Dependent or Representative Date

This form can be sent by mail or fax to :

Mail: OGB
Medical/Pharmacy Section
P.O. Box 44036
Baton Rouge, LA 70804

Fax: OGB
Medical/Pharmacy Section
(225) 342-9917