



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, and may not begin before April 14, 2003)

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.

Signature of Health Plan Member/Dependent or Representative

Date