

**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:

Health Plan Member/Dependent Name: _____

Date of birth: _____

Address: _____ **Telephone:** _____

Member Health Plan 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.

Signed: _____ Date: _____
Health Plan Member/Dependent
or Representative