

# Accounting of PHI Disclosures Request Form



**Mail to:** Western Health Advantage Mail Service, Attn: Member Services  
PO Box 4457, Portland, OR 97208-4457

**Fax to:** 916.678.5440

**Questions?** 916.563.2250 | 888.563.2250 toll-free | 711 TTY

## Member Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

WHA Member ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Apt./Unit# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

This form will allow a member to request for an accounting of Protected Health Information (PHI) disclosures made by Western Health Advantage (WHA) or a business associate acting on behalf of WHA.

**Requested time period:** (limited to 6 years prior to request)

From (month/year) \_\_\_\_\_ to (month/year) \_\_\_\_\_

## Information to be released to:

Me, at the address:  on record with WHA or  listed in this request

Another person/entity (Please specify recipient name and complete address):

Name \_\_\_\_\_

Address \_\_\_\_\_

Me, or my personal representative, in person upon pick up at the WHA office. Please contact me by phone or email when the document/s is/are ready.

Phone \_\_\_\_\_

Email \_\_\_\_\_

Western Health Advantage is an HMO plan with a Medicare contract. Enrollment in the health plan depends on contract renewal.

**I understand and agree to the following:**

- The following are excluded from an accounting of disclosures:
  - Disclosures made by WHA for purposes of treatment, payment, and healthcare operations
  - Disclosures to me (member) or authorized by me (member) or my personal representative
  - For national security or intelligence purposes
  - To law enforcement or correctional institutions
  - Disclosures incident to a use or disclosure otherwise permitted or required by law
  - As part of a limited data set, when the recipient has executed a data use agreement, PHI was disclosed for research, public health, or certain health care operations purposes
- My request will be processed within sixty (60) days, or I will be informed in writing of the need for an extension of not more than 30 additional days to process the request.
- I am entitled to a free accounting of disclosures in any 12 month period. For additional/subsequent accounting in the same 12 month period, I may be charged a fee. I may modify or withdraw my request.
- If I send a completed form by email to WHA, I acknowledge that it is not best practice to send protected health information through email that is not secure.

**WHA Member Signature** \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**Personal Representative Signature** \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Please check the box that describes your relationship to the member/enrollee:

Parent of Minor    Legal Guardian    Power of Attorney    Executor

Other \_\_\_\_\_

Documentary proof of your relationship/authorization must be attached to this request, otherwise it cannot be processed or may be denied. If you are requesting an accounting on behalf of a minor, federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor 12 years of age or older.

**Keep a copy of this for your records.**

**WHA Internal Use Only**

Date Request Received \_\_\_\_\_ Date Request Fulfilled \_\_\_\_\_

Identification Verified (documents checked)

If there were no applicable disclosures for the period, date Member notified \_\_\_\_\_

Signature of Manager or Supervisor \_\_\_\_\_

Printed Name \_\_\_\_\_