

request for an accounting of disclosures of personal information

Member ID number: _____ Member name: _____

Member address: _____

Member telephone: _____ - _____ - _____ Member date of birth: ____ / ____ / ____

On ____ / ____ / ____ you contacted Fallon Community Health Plan to request an accounting of disclosures for the following time frame: (Please note: For requests for an accounting of disclosures made prior to April 13, 2003, FCHP provides a list of entities who may have received the disclosure.)

From: _____ To: _____

An accounting of disclosures of your protected health information (PHI) only includes disclosures that are not related to your treatment, payment of your claims, FCHP's operations, or disclosures that were authorized by you or your personal representative.

Fees:

First request in a 12-month period..... No charge

Subsequent requests in a 12-month period FCHP charges a fee based on an hourly rate for research time.

Date of last request (if any): _____

I understand that if I have already received an accounting in the past 12 months, there is a fee for this accounting, and I wish to proceed. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Member (or personal representative) signature: _____

Relationship to member (if personal representative): _____

Print name: _____ Date: _____

Mail completed form to:

Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

FOR FCHP USE ONLY

Date received: _____

Date sent: _____

Extension requested: No _____

Yes, reason: _____

Member notified in writing on this date: _____

