Request for an Accounting of Disclosures of Personal Information

Member name: _____ Member ID number: _____

Member address: _____

Member telephone: _____ Member date of birth: _____

On ____/____/____ you contacted Fallon Health to request an accounting of disclosures for the following time frame:

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, Fallon's operations, or disclosures (unless they are in a readily producible electronic format) 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 - Fallon charges a fee based on an hourly rate for production 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 Health
10 Chestnut St.
Worcester, MA 01608

FOR FALLON USE ONLY

Date received: _____ Date sent: _____
Extension requested: No _____ Yes, reason: _____
Member notified in writing on this date: _____