Return To: CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121

REQUEST FOR ACCOUNTING OF PROTECTED HEALTH INFORMATION (PHI) DISCLOSURES

Use this form to request an accounting of when your PHI has been disclosed by CountyCare. If you need assistance completing the form, please contact the Customer Service number at **312-864-8200.**

I. MEMBER INFORMATION: (individual for whom an accounting of PHI disclosures is being requested)

Name: _____

Address: _____

Member ID #: _____ **Date of Birth:** _____

II. PLEASE READ THE FOLLOWING:

- This request only applies to disclosures made by CountyCare, or entities acting on behalf of CountyCare. It does not include disclosures that may have been made by your provider(s). To request an accounting of disclosures made by those entities, you should contact them directly.
- The accounting will not include disclosures that CountyCare made for treatment, payment, or healthcare operations purposes, or disclosures made with your authorization or permission, or disclosures exempted from accounting under law.
- You are entitled to receive one free disclosure accounting per 12 month period. CountyCare may charge a fee to process additional requests received with that period.
- The accounting will be provided to you within 60 days unless you are notified in writing that an extension of up to 30 days is needed.
- Your request will not be considered until CountyCare receives all information requested in this form.

III. PLEASE INDICATE THE TIME PERIOD FOR THE DISCLOSURE ACCOUNTING BEING REQUESTED:

Note: Time period cannot exceed six (6) years prior to date of request.

From: _____ To: _____
month/day/year month/day/year

IV. PLEASE INDICATE WHERE/HOW YOU WOULD LIKE TO RECEIVE THE ACCOUNTING:

☐ Please send the accounting of disclosures to the address below:

_____

☐ Please send the accounting of disclosures to the email address below:

_____

V. SIGNATURE

I request that CountyCare Health Plan send me an accounting of disclosures of my PHI. I have read and understand the above information.

If the member cannot sign, only the member's legal representative may sign. If you are the member's legal representative, describe this below and send CountyCare Health Plan copies of those forms (such as power of attorney or order of guardianship). Members 18 years or older must sign the form on their own behalf.

Signature of Member: _____ Date: _____

Signature of Representative (if applicable): _____

Relationship to the Member: _____

FOR COUNTYCARE USE ONLY

Date accounting request received: _____ *Extension requested:* ☐ *Yes* ☐ *No*

Reason for extension (if yes): _____

Date Accounting Provided to Member: _____ *By email* ☐ *By email* ☐

Name of staff member processing request: _____