

Request for Accounting of Plan's Disclosures of Protected Health Information (PHI)

Complete the following chart with information about the person whose PHI is subject to this request.

| Name (Last, First, MI): | |
|---------------------------|--|
| Address (City,State,Zip): | |
| Phone: | |
| Date of Birth: | |

If you are not the employee, complete the following:

| Employee Name: | |
|-------------------------|--|
| Employee ID #: | |
| Employee Date of Birth: | |

I am requesting that I be provided an accounting of the disclosures of the following PHI for the above noted individual during the time period starting_____

and ending______. I understand that the accounting will not include disclosures for which an accounting is not required under the HIPAA privacy rules. I also understand that where the Plan provides an accounting to me, it will provide it once free of charge within a (12) month period. Any additional request for an accounting within the twelve (12) month period will be subject to a reasonable cost based fee.

State the specific PHI that is being requested:

If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this request. (A personal representative may be requested to provide verification of representative status.)

| Signature of applicant or | nal representative | Date | |
|--------------------------------------|--------------------|--|----------------|
| Relationship of personal | repres | sentative to member: | |
| Send completed form to: | | Privacy Official Human Resources 7575 E. Main Street Scottsdale, AZ 85251 Phone: (480) 312-7600 FAX: (480) 312-7960 | |
| Request approved Extension needed | | Reason: Date information will be provided | |
| Request denied | | Reason for denial | |
| By: COS Signature | | Date | Name and Title |