Request for an Accounting of Disclosures

Health Insurance Portability and Accountability Act of 1996 45 CFR 160 §164.528

Please fill out the form below to request that Hill Physicians Medical Group provide you an accounting of all disclosures of your PHI as required under the HIPAA regulations.

Is this request for yourself? (Required)

☐ Yes, this request is for myself ☐ No, this request is on behalf of someone

Individual's First and Last Name

Prefix _____ First _____ Last _____

If by mail, please forward any information to the following address: (Required)

*Please specify address here _____

If contact is made by telephone, please contact me or my representative at: (Required):

*Please specify phone number here _____

I am the authorized representative of: (Required) _____

I am submitting this request for an Accounting for and on behalf of the above Individual for the following reason: (Required)

_____

_____

_____

_____

Individual's Health Plan Member Number (Required) _____

Consent: (Required)

☐ I request that Hill Physicians Medical Group provide to me an Accounting of all disclosures of my PHI as required under the HIPAA regulations.

Accounting Period (Required): (Start Date) _____ (End Date) _____
Accounting period not to exceed 6 years

—Form continued on back

Limitations of accounting: (Required)

☐ All disclosures ☐ Only disclosures to (Please Specify)

Provide Disclosures To: (Required)

_____

_____

_____

_____

Other (please describe):

_____

Consent: (Required)

☐ I understand that I have the right to receive the accounting within sixty (60) days of Hill Physicians' receipt of the request or no later than ninety (90) days of the date of receipt if Hill Physicians requests an extension in writing;

Consent: (Required)

☐ I understand that I have the right to receive one (1) accounting free in any twelve (12) month period. PriMed and/or Hill Physicians may charge a reasonable cost-based fee for additional requests from me within the same 12-month period, provided that PriMed and/or Hill Physicians advises me in advance of the fee and provides me with an opportunity to withdraw or modify the request in order to reduce or avoid a fee.

Consent: (Required)

☐ I understand that the following list of disclosures is excluded from the accounting requirements and any information regarding such disclosures, if any, will not be included in the accounting:

1. To carry out treatment, payment or healthcare operations;
2. Information about me that is shared with me;
3. That are incidental;
4. In facility directories;
5. Involving or notifying family members or other individuals involved in my care or payment for that care;
6. Of a limited date set;
7. Made with my authorization;
8. For national security or intelligence purposes;
9. To correctional institutions of for law enforcement officials having lawful custody of me; and
10. That occurred more than six years prior to the date of this request and disclosures that occurred prior to April 14, 2003.

Consent: (Required)

☐ The contents of the accounting shall be in a form of Hill Physicians' choosing and shall contain a minimum of the following information:

1. The date of each, if any, disclosure;
2. The name of the entity or person who received each disclosure of PHI and, if known, the address of such entity or person;
3. A brief description of the PHI disclosed; and
4. A brief statement regarding the purpose of the disclosure.

Signature: (Required)_____Print Name_____

Your Title: (Required)_____ **Dated: (Required)**_____

Please return this form to Hill Physicians by mail or fax:

Mail

Hill Physicians Medical Group
Attn: Customer Service
P.O. Box 5080
San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Customer Service

