Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

Request for Accounting of Disclosure of Protected Health Information (PHI)

I hereby exercise my right under the HIPAA Rules to an accounting of certain disclosures of my Protected Health Information. These disclosures may have been made by the Plan, or Business Associates of the Plan.

I understand that the Plan is not required to provide an accounting of the following disclosures: 1) disclosures to me, 2) disclosures for the purpose of Treatment, Payment, Health Care Operations, 3) disclosures that are incidental to disclosures permitted by the HIPAA Rules, 4) disclosures made pursuant to my written authorization, 5) disclosures to persons involved in my care, and pursuant to my oral or written consent, 6) disclosures to authorized individuals for purposes of national security, 7) disclosures to a correctional facility or Law Enforcement Official that had or has lawful custody of me, 8) certain disclosures made for research purposes that are part of a limited data set, 9) disclosures that were made more than six years before the date of this request, and 10) disclosures that occurred before April 14, 2003. I understand that my rights to an accounting of disclosures may be suspended temporarily if the accounting will impede the activities of a health oversight agency or law enforcement agency.

I understand that I am entitled to receive this accounting free of charge one time in a twelve-month period. I will be charged a reasonable charge of 15 cents a copy plus a $10 administrative fee for additional requests.

Participant Name: _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

_____

Participant Social Security Number: _____

Request is for relevant disclosures made by the Plan and its Business Associates from

date: _____ **to date:** _____.

Check one:

☐ **I have made a request for an accounting of disclosures within the past twelve months.**

☐ **I have not made a request for an accounting of disclosures within the past twelve months.**

Signed: _____ Date: _____
Signature of Participant

Signed: _____ Date: _____
Signature of HIPAA Compliance Director or designee