



APWU Health Plan Accounting of Disclosures of Protected Health Information

With this form, you may exercise your right to receive an accounting of disclosures of your Protected Health Information. APWU Health Plan is required to keep and track all disclosures of Protected Health Information, except for treatment, payment or health plan operations. The accounting will include who requested the information, when it was requested, the reason and type of Protected Health Information that was disclosed. You must complete, sign and date, and submit this form to APWUHP. Upon receipt we will process your request within 60 calendar days.

Please print neatly to ensure accurate processing and to avoid delays in service.

1. Member Information:

Policy Holder/Member's ID# _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: ____/____/____

Member's Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ - _____ - _____ Work Phone Number: _____ - _____ - _____

Policy Holder's Name: _____

2. I am requesting an accounting of disclosures of my Protected Health Information by the APWU Health Plan and its Business Associates. The APWU Health Plan and/or its Business Associates will limit such an accounting in accordance with applicable law. I understand that I am allowed one (1) free accounting in a twelve (12) month period.

I request the accounting be from start date: _____ to end date: _____.

The APWU Health Plan will honor requests with a start date after April 14, 2003. The APWU Health Plan will provide an accounting in accordance with the law, for a period not greater than six (6) years.

I understand that I will receive a response to or be given the status of my request within (60) sixty days from the APWU Health Plan's receipt of the request.

3. Signature: _____ Date: _____

4. Please mail this Access to Protected Health Information Request to:

APWU Health Plan
Attn: Privacy Specialist
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061
1-800-222-2798

