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

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

1. **Requestor Information:**

   Requestor ID#: _____

   First Name: _____ MI: _____

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

   Address: _____

   City: _____ State: _____ Zip: _____

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

   E-mail Address: _____

2. I am requesting an accounting of disclosures of my Protected Health Information by the APWU Health Plan and its Business Associates. 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 provide an accounting in accordance with the law, for a period not greater than six (6) years from the date this request is received by the APWU Health Plan.

   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 this request.

3. **Signature:** _____ **Date:** _____

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

   APWU Health Plan
   HIPAA Privacy/Security Specialist
   799 Cromwell Park Drive; Suites K-Z
   Glen Burnie, MD 21061

   1-800-222-2798