Information About Your Request for an Accounting of Disclosures

What does the right to an accounting of disclosures mean?

You may ask for a list of the times over the past six years when we shared your protected health information (PHI) with another person or organization. This includes the times we shared your PHI outside of disclosures allowed by law.

What do I need to know to use this right?

The list will not include the times when your information was shared:

- With you or your personal representative;
- With your authorization;
- For your treatment;
- To pay for your health care;
- For our health care operations;
- For national security or intelligence purposes;
- With correctional institutions or law enforcement; or
- As part of a limited data set for research or public health activities.

Community Health Plan of Washington will respond to this request within 60 days. If we cannot respond within 60 days, we will send you a written notice telling you why there is a delay and when we will act on your request.

How much will this cost?

If you ask for a list more than once every 12 months, we may charge you a fee for copying and mailing. If there is a fee, we will tell you how much it will be so you can decide if you want to change or cancel your request.

How do I make a request?

Complete and print the attached form, then mail it to the address at the end of the form.

How will I know if my request is processed?

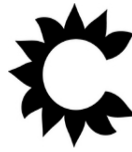
We will send a letter to the address you write on the form. The letter will tell you if we approved or denied your request.

How can I get a full notice of my privacy rights?

A full notice of your privacy rights is on the Community HealthFirst web site at: http://healthfirst.chpw.org/for-members/your-rights-and-privacy/

You may also request a copy by calling the Community Health Plan of Washington's Customer Service department at 1-800-942-0247, 7 days a week, from 8am to 8pm. If you are hearing or speech impaired, please call TTY 7-1-1 (toll free).

REQUEST FOR AN ACCOUNTING OF DISCLOSURES



Section A: Member Information

Member Name: ______________________ Date of Birth: ______________

Member ID #: ______________________ Date of Request: ______________

Address: ____

City: ______________________ State: ______ Zip Code: __________

Phone: ______________________ Fax: ______________________

Choose One:

☐ OK to leave message with detailed information ☐ Leave message with call back number only

Section B: Details of the Request

Request for an Accounting of Disclosures of Protected Health Information

For the time period below, provide a list of the times you shared my protected health information, above and beyond the disclosures allowed by law:

From: Month: ______________ Year: ______________

To: Month: ______________ Year: ______________

Section C: Signature and Date

Member or Representative Name: ____

Member or Representative Signature: ______________________ Date Signed: ______________

Please complete the form and return a copy to:

Community Health Plan of Washington
Attention: Compliance, Privacy and Privacy Officer
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: compliance.officer@chpw.org

Please type or print neatly. We will not process incomplete or illegible forms.