REQUEST FOR AN ACCOUNTING

OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Mail To: Privacy Officer, Riverside Physician Network

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we protect the privacy of your protected health information. You have the right to receive an accounting of certain disclosures of your protected information. **This request must be made in writing, and any accounting will only include disclosures made during the past six years, but no early than April 14, 2003.** Riverside Physician Network must act on your request within 60 days, unless we provide you with notification in writing that an extension of up to 30 days is needed. The first accounting you request in any 12-month period will be provided free of charge. There will be a cost-based fee for any subsequent request for accounting made by you within the same 12-month period.

Pursuant to HIPAA regulations and Riverside Physician Network's *Right to Accounting of Disclosures of Protected Health Information,* the following types of disclosures will NOT be accounted for:

- Disclosures made to carry out health care treatment, payment, or operations;
- Disclosures made to you about your protected health information;
- Disclosures incidental to a use or disclosure otherwise permitted or required under HIPAA;
- Disclosures made pursuant to an authorization signed by you;
- Disclosures made for use in a medical facility directory;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to correctional institutions or law enforcement;
- Disclosures made as part of a limited data set (protected health information that excludes direct Identifiers of the individual) or;
- Disclosures made prior to April 14, 2003.

Date of Request: _____

On the date written above, I request an accounting of disclosures (other than those listed above) made by Riverside Physician Network of my protected health information made between _____ and _____.

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ ___ Apt #: _____

City: _____ State: _____ Zip: _____

Health Plan Member ID: _____ Date of Birth: ____/_____/_____

Signature: _____

Parent of Legal Guardian may sign on behalf of minor child. Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult-documentation is required.

If signing on behalf of another person, please provide the following information:

Name of Designated Personal Representative: _____

Relationship to Individual: _____