REQUEST FOR ACCOUNTING OF PHI DISCLOSURE(S)

BY COMPLETING AND SUBMITTING THIS FORM, I AM REQUESTING AN ACCOUNTING OF MY PROTECTED HEALTH INFORMATION (PHI)

I understand that such accounting will be limited to disclosures that were not for the purposes of treatment, payment or health care operations and for which I have not provided a written authorization. I realize that most disclosures of PHI are for treatment, payment, or health care operations. The accounting will not include any information disclosed in the six years prior to the date the accounting is requested.

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items).

Name of Customer: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Employee ID No.: _____

Group or Account No. on ID Card: _____

Subscriber Name (if different from Customer): _____

Subscriber Relationship to Customer: _____

REQUEST

I am requesting information about disclosures of the following types of information:

- ☐ Medical Care
- ☐ Dental Care
- ☐ Mental health/behavior health care (Please make sure you have coverage through the City of Houston Self-insured Medical Group Health Plans Behavior Health before you request this information

Send to the following address: _____

_____

PLEASE NOTE

- *The accounting will not include periods prior to April 14, 2003.*
- *One accounting per 12-month period is provided free; the City of Houston Self-insured Medical Group Health Plans may charge for any additional accounting*
- *This accounting of your protected information only includes disclosures made by the City of Houston Self-insured Medical Group Health Plans and its affiliates. It does not include disclosures that may have been made by the subscriber's employer/group health plan, their business associates, or other*

insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.

- *I understand that if the information on this form is not complete, the Plans' administrators will return the form to me, and this request will not be considered until complete information has been received.*
- *If any enrollment information such as Social Security Number (SSN), Member ID or Date of Birth is changed, another form will need to be completed at that time.*
- *If either the Customer or Group changes to a different type of health care benefits coverage provided by the City of Houston Self-insured Medical Group Health Plans, another form will need to be completed at that time.*

SIGNATURE

I have read and understand the above information. Date: _____

Signature of Customer, Parent/Guardian, Personal Representative: _____

Relationship if signed by other than Customer: _____

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Customer is a minor _____ years of age.
If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Signature of Customer, Parent/Guardian, Personal Representative: _____

Please Return This Completed Form To:
Privacy Officer
City of Houston Self-Insured Medical Group Health Plans,
Human Resources Department, 611 Walker, 4th Floor, Houston, Texas 77002
Email: PrivacyOfficer@houstontx.gov; FAX: 832.393.7208.