Accounting of PHI Disclosures Request Form

Western Health Advantage

Mail to: Western Health Advantage Mail Service, Attn: Member Services
PO Box 4457, Portland, OR 97208-4457
Fax to: 916.678.5440
Questions? 916.563.2250 | 888.563.2250 toll-free | 711 TTY

Member Information

First Name _____ Last Name _____ MI _____

WHA Member ID#_____ Date of Birth _____

Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

This form will allow a member to request for an accounting of Protected Health Information (PHI) disclosures made by Western Health Advantage (WHA) or a business associate acting on behalf of WHA.

Requested time period: (limited to 6 years prior to request)
From (month/year) _____ to (month/year) _____

Information to be released to:

❏ Me, at the address: ❏ on record with WHA or ❏ listed in this request

❏ Another person/entity (Please specify recipient name and complete address):

Name _____

Address _____

❏ Me, or my personal representative, in person upon pick up at the WHA office. Please contact me by phone or email when the document/s is/are ready.

Phone _____

Email _____

Western Health Advantage is an HMO plan with a Medicare contract. Enrollment in the health plan depends on contract renewal.

I understand and agree to the following:

- The following are excluded from an accounting of disclosures:
  - Disclosures made by WHA for purposes of treatment, payment, and healthcare operations
  - Disclosures to me (member) or authorized by me (member) or my personal representative
  - For national security or intelligence purposes
  - To law enforcement or correctional institutions
  - Disclosures incident to a use or disclosure otherwise permitted or required by law
  - As part of a limited data set, when the recipient has executed a data use agreement, PHI was disclosed for research, public health, or certain health care operations purposes
- My request will be processed within sixty (60) days, or I will be informed in writing of the need for an extension of not more than 30 additional days to process the request.
- I am entitled to a free accounting of disclosures in any 12 month period. For additional/subsequent accounting in the same 12 month period, I may be charged a fee. I may modify or withdraw my request.
- This request must be accompanied by a copy of a photo ID of the person signing the form and of the recipient, unless one is already on file with WHA.
- If I send a completed form by email to WHA, I acknowledge that it is not best practice to send protected health information through email that is not secure.

WHA Member Signature _____ Date _____

Print Name _____

Personal Representative Signature _____ Date _____

Print Name _____

Please check the box that describes your relationship to the member/enrollee:

❑ Parent of Minor ❑ Legal Guardian ❑ Power of Attorney ❑ Executor

❑ Other _____

Documentary proof of your relationship/authorization must be attached to this request, otherwise it cannot be processed or may be denied. If you are requesting an accounting on behalf of a minor, federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor 12 years of age or older.

Keep a copy of this for your records.

WHA Internal Use Only

Date Request Received _____ Date Request Fulfilled _____

❑ Identification Verified (documents checked)

If there were no applicable disclosures for the period, date Member notified _____

Signature of Manager or Supervisor _____

Printed Name _____