Instructions to complete the Highmark Health Options Request for Accounting of Disclosures of Protected Health Information Form

Section A: Member Information

1. Write the first and last name of the member whose information is being requested.
2. Write the member's identification number.
3. Write the member's address.
4. Write the member's date of birth.
5. Write the member's telephone number.

Section B: Information Requested:

1. Write a start date and an end date of which you are requesting an accounting of all disclosures.

   Please note that we cannot include disclosures that were made prior to April 14, 2003 because we were not required to collect this disclosure information until after that date.

2. Check where Highmark Health Options should mail a copy of the PHI you are requesting. If you are requesting the accounting be mailed to a person other than yourself and/or an address other than the address that is associated with your account, please indicate that in the fields provided.

Section C: Signature

1. This Authorization must be signed and dated by the member whose information is to be released.
2. If the member is unable to sign this Authorization, a personal representative with legal authority on file with Highmark Health Options may sign and date the form. If a personal representative is signing the form on the member's behalf:
   a. Write the personal representative's relationship to the member.
   b. Write the personal representative's telephone number.
   c. Write the personal representative's address.

Section D: Personal Representatives

If you are completing this form on behalf of a Highmark Health Options member please indicate in this section the legal authority that gives you this right (i.e. Personal Representative form, Healthcare Power of Attorney, legal guardianship, etc.).

If you have not already done so, you will be required to complete an Authorization to Use and Disclose Form and submit it to Highmark Health Options. If the form is not on file when we receive this form, the request will be denied. The form can be obtained and returned in the same manner as the Accounting Request Form.

HIGHMARK HEALTH OPTIONS

Member Request for an Accounting of Disclosures of Protected Health Information

Section A: Member Information: (Please Print)

Member Name:	Member ID:
Address:	
Date of Birth:	Telephone:

Section B: Information Requested:

As a Highmark Health Options member, you have the right to request an accounting of disclosures of your health information for purposes other than treatment, payment for care, or routine business operations. Our Notice of Privacy Practices provides a detailed description of how we may use or disclose your information.

I would like an accounting of all disclosures made during the following time period:

Start date: ____/____/_____ End date: ____/____/_____

Please note that we cannot include disclosures that were made prior to April 14, 2003 because we were not required to collect this disclosure information until after that date. You may not request an accounting of disclosures made before April 14, 2003 or disclosures made more than six years prior to the date of your request. We will provide only disclosures occurring after the date of your last request for an accounting.

☐ I request that a copy of PHI about myself be mailed to me at the address above.

☐ I request that a copy of PHI about myself be mailed to me at the address listed below:

☐ I request that a copy of PHI about myself be mailed to _____ at the following address:
(designated person)

Address:

Section C: Signature

I understand that Highmark Health Options does not have to tell me about disclosures for purposes of treatment, payment and health care operations or as part of a limited data set.

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

I understand that Highmark Health Options does not have to tell me about disclosures to me, disclosures authorized by me, disclosures to persons involved in my care, or for notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).

I understand the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

I understand that Highmark Health Options does not have to tell me about disclosures for national security or intelligence purposes, disclosures to correctional institutions or law enforcement officials, or disclosures incident to a use or disclosure otherwise permitted or required by state or federal law. I also understand that my right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

I understand that if my request for accounting of disclosures request is denied, I may have the right to request a reconsideration of the denial decision. I must submit my request for reconsideration in writing to:

Highmark Health Options WV
Attn: Enrollee Services
614 Market St.
Parkersburg, WV 26101

I understand that any form returned to Highmark Health Options incomplete will be returned to me for completion and my accounting request will not be implemented until all the information is received complete and processed.

Signature: _____ Date: _____

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (i.e. general power of attorney) that verify the signer's authority to act for the member.

Section D: If you are a Personal Representative filling out this form for a Highmark Health Options member, please write that relationship below and the legal reason that gives you this right (i.e. Power of Attorney, guardian, etc.). If you have not done so, you will be required to fill out an Authorization to Use and Disclose Form and send it to Highmark Health Options. You can get the form and return it in the same way as the Accounting Request Form.

If you are not the member, print your name:	Relationship to member:
Legal form on file:	Telephone number:
Address:	

HIGHMARK. HEALTH OPTIONS

Discrimination Is Against the Law

Highmark Health Options complies with applicable Federal civil rights laws and regulations and does not discriminate on the basis of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options does not exclude people or treat them differently because of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Help in Your Language

Highmark Health Options provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do kat idantifikasyon w lan (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：(TTY: 711）。

注：英語を話す場合は、無料の言語支援サービスを利用できます。 あなたのIDカードの裏面（：711 TTY）の番号を呼び出します。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ તો, તમારા માટે ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમારા આઇડી કાર્ડની પાછળ આપેલા નાંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 카드 뒷면의 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: Se parla italiano, per Lei sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero presente sul retro della Sua carta di identificazione (TTY: 711).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tawagan ang numero sa likod ng iyong card (TTY: 711).

कृपया ध्यान दें: यदि आप हिन्दी बोलते है, तो भाषा सहायता सेवाएं आपके लिए निशुल्क उपलब्ध है। अपने पहचान कार्ड के पीछे दिए गए नंबर पर कॉल करे (TTY: 711)।

توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ کے پیچھے درج نمبر پر ہمیں کال کریں (ٹی ٹی وائی: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل على الرقم المدوّن على ظهر بطاقة هُويتك (الهاتف النصي: 711).

గమనిక: మీరు తెలుగు మాట్లాడే వారైతే, భాషా సహాయక సేవలు, ఖర్చు లేకుండా, మీరు లభిస్తున్నాయి. మీ ఐడి కార్డుకు (TTY: 711) వెనుక వైపు ఉన్న నంబర్‌కి ఫోన్ చేయండి.