Collective Health

REQUEST FOR ACCOUNTING OF DISCLOSURES

Collective Health is contracted by your employer-sponsored health plan ("Health Plan") to administer your Health Plan's benefits. Use this form to request an accounting of how your protected health information (PHI) was disclosed by your Health Plan, Collective Health, and/or their business associates. Such accounting will not include those disclosures exempted from accounting under the law.

PLEASE UPLOAD THE COMPLETED FORM AS A NEW MESSAGE IN YOUR MY COLLECTIVE PORTAL OR MAIL TO US AT: COLLECTIVE HEALTH, ATTN: PRIVACY OFFICE, 1557 W. INNOVATION WAY, SUITE 300, LEHI, UT 84043.

Section A: The individual who is requesting an Accounting of Disclosures must complete the following:

Name	**Subscriber ID #**	**Date of Birth**	
Address	**City**	**State**	**ZIP**
Telephone Number	**E-mail Address (if available)**		

Section B: Please complete the following about the Accounting of Disclosures request. Note: time period cannot exceed six (6) years from the date of request.

I request an accounting of disclosures of my PHI that were made during the following timeframe: from _____/_____/_____ to _____/_____/_____.

Please send the accounting of disclosures to me at:

_____

Section C: Signature - This document must be signed by the individual, parent of minor child or the individual's personal representative.

I request that my Health Plan, Collective Health, and their business associates provide me an accounting of disclosures as described in Section B. I understand that I can sign on behalf of a child as their parent only if they are under the age of 18, unless there is proof of other legal authority.

_____ _____

Signature* **Date: month/day/year**

**If you are signing as a power of attorney, legal guardian, executor, or administrator, attach a copy of the legal documents granting authority.*