PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

AFN: HIP-010 (12/2022)

Participant Name: **Participant ID #:**

I hereby request Public Safety/Corp Cancer Insurance Policy Program to provide me with an accounting of disclosures made of my protected health information during the following period:

Period Requested:

Note: Period requested cannot be more than six years prior to the date on which this accounting is requested.

And mail them to me at the following address:

Address1: **Home Phone:**

Address2: **Work Phone:**

City, State, Zip:

I understand that this accounting will not reflect disclosures:

1. That are made to carry out treatment, payment and health care operations
2. Made to me or my personal representative
3. Made to persons involved in my care or for purposes of notifying or identifying persons involved in my care
4. For national security or intelligence purposes
5. To correctional institutions or law enforcement officials
6. Made prior to six years from the date of this request or such shorter time period at your request
7. Made pursuant to an authorization
8. That are incidental to other permissible uses or disclosures
9. That are part of a limited data set (does not contain protected health information that directly identifies individuals)

And I understand that there may be a fee associated with the request which is:

Fee: **Fee Schedule:** First request in a 12 month period: **Free**

Subsequent Requests:

And I understand that:

Within 60 days, I will receive a response from Public Safety/Corp Cancer Insurance Policy Program, or a notification that they require an additional 30 days to process my request. If they require an extension, they will explain the reason for the delay and the date by which they will complete my request.

Date: *(MM DD YYYY format)*

Signature of Participant or Legal Representative

(Participant or Legal Representative, Your 'Typed' First and Last Name Constitutes Your Signature.)

Relationship to Participant (*if applicable*)

- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Printed Name of Participant's Representative (*if applicable*)

Submit Form

PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM
REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)
AFN: HIP-010 (12/2022)

**** For Office Use Only ****

ID Verification Completed By:

Date Verification Completed:

(MM DD YYYY format)

Notes:

Temporarily Suspended (*if applicable*):

Under 45 CFR §164.528(a)(2), disclosure is temporarily suspended by a (*Check One*)

Health Oversight Agency or Law Enforcement

Agency Name: **Agency Phone:**

Agency Contact Name: **Suspended Until Date:**

Date Request Received: **Received By:**

Date Request Fulfilled: **Fulfilled By:**

Extension Requested: **Yes** **No**

Date Participant Notified in Writing of Extension:

If Extension Requested, Give Reason: