GEHA

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REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Accounting of Disclosures request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

- ☐ GEHA Health Plan (includes Connection Vision Plan)
- ☐ GEHA Connection Dental Federal Plan (includes Connection Vision Plan)
- ☐ CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)
- ☐ CONNECTION Vision Plan only

You have the right to request a copy of disclosures of your protected health information up to 6 years prior to your request. This does not include disclosures (1) related to treatment, payment and health care operations, (2) made to you as the patient, (3) made to a personal representative, (4) consistent with the notice of privacy, (5) made to any person(s) whom you authorized GEHA to release information, (6) for a person(s) involved in your care, (7) for national security or intelligence purposes, (8) to correctional institutions or law enforcement officials, or (9) as part of a limited data set.

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED.

Subscriber/Member Information:

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Patient Name: _____ **Date of Birth:** _____

Dates for the accounting of disclosures: _____

GEHA and GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc. (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com), must act on a request for accounting of disclosures no later than 60 days after the receipt of the request. GEHA and its representatives may take up to 90 days, in which case GEHA will send you a written statement of the reason(s) for the delay and the date by which the accounting will be provided. You will be notified in writing regarding the accounting.

The first accounting to an individual in any 12-month period will be provided without charge. A reasonable, cost-based fee for each subsequent request may be made. You will be informed in advance of the fee and provided the opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

By signing this form, I am requesting an accounting of disclosures of my protected health information disclosure for the above noted dates.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, medical power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED TO:

GEHA
ATTN: Accounting of Disclosures
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283