ACCOUNTING OF DISCLOSURES REQUEST FORM

Complete this form and return to: Privacy Compliance Administrator, Corporate Compliance, Capital District Physicians' Health Plan, Inc., 6 Wellness Way, Latham, NY 12110 or Fax:518-641-5504

I. MEMBER INFORMATION

Date of request: _____Date of birth:_____

Name:_____

CDPHP Identification #: _____Telephone Number:_____

II. DATES REQUESTED

I would like an accounting of all reportable disclosures for the following time frame. *Please note: CDPHP is not required to account for disclosures that occurred before April 14, 2003.*

From:_____ To:_____

III. INFORMATION REQUESTED

Select one of the following:

___ I wish to receive an accounting of all reportable disclosures

___ I wish to receive an accounting of all reportable disclosures related to:
(*Please specify: For example, disclosures related to a type of injury or benefit.)*

_____

IV. ADDRESS INFORMATION

Indicate the address where the information should be sent:

_____

_____

V. SIGNATURE

I am requesting the information noted above in my capacity as *(select one):*

___ Self ___Parent ___Guardian ___Legal Representative *(attach signed authorization form)*

___Other (explain):_____

Signature of member
or legal representative_____ Date _____