ProCare Rx

Request for Accounting of Disclosures of Protected Health Information (PHI)

WHY THIS FORM?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request an amendment to your PHI in the Designated Record Set (DRS) that is maintained by EHIM, Powered by ProCare Rx, or its Business Associate (BA). Please complete this form in its entirety so that we may provide you with the correct information you are requesting.

A. Member Information

Last Name:	First Name:	Middle Name:	
Date of Birth:	EHIM Member #:	Phone #:	
Address:	City:	State:	Zip:

B. Disclosure Information

1. **Accounting of Disclosures Date Range.** Unless otherwise indicated, I will receive an accounting of disclosures made in the last twelve (12)-month period. I understand and acknowledge the maximum accounting period is six (6) years prior to my request, but not prior to April 14, 2003.

   I hereby request an accounting of disclosures of my PHI from Start Date:_____ TO End Date:_____

2. **Access to an Accounting of Disclosures.** The request will be mailed to the Member, unless I specify below. I hereby request an accounting of disclosures to be mailed to the following individual and/or entity and address:

   Name: Address:

3. **Denial of Request.** I understand and acknowledge that **EHIM WILL NOT PROVIDE ME WITH THE FOLLOWING DISCLOSURES**: (1) to carry out treatment, payment and/or health care operations, including plan payment and administration functions; (2) made to me or my personal representative; (3) pursuant to an authorization from me or my personal representative; (4) to the individual(s) and/or entity(ies) involved in my care; (5) incidental to a permissible use and/or disclosure; (6) for national security and/or intelligence purposes; (7) to correctional institutions and/or law enforcement officials; (8) de-identified data; (9) that occurred prior to the compliance date of April 14, 2003; and (10) that occurred beyond the past six (6) years. I further understand and acknowledge **MY REQUEST FOR AN ACCOUNTING OF DISCLOSURES MAY BE DECLINED IF:** (1) the request is not reasonable; (2) the information I provide is not accurate; (3) this form is not completed in its entirety; and/or (4) I do not sign below. If EHIM denies this request, it will provide me with a written explanation of the reason(s).

4. **Rights and Acknowledgement.** With certain exceptions, I have a right to receive an accounting of disclosures of my PHI. If I have any questions about accounting of disclosures, I may refer to EHIM, Powered by ProCare Rx, Notice of Privacy Practices ("NPP") under HIPAA which may be accessed on its website at www.ehimrx.com and/or may be provided upon request by contacting EHIM, Powered by ProCare Rx, at (800) 311-3446. By signing below, I hereby request to receive an accounting of disclosures of my PHI by EHIM, Powered by ProCare Rx. EHIM, Powered by ProCare Rx, is required to keep and track all disclosures of PHI (except for treatment, payment or health plan operations), including those made to or by its BAs. EHIM, Powered by ProCare Rx, will have up to sixty (60) days after receiving this request to act on it, and that under certain circumstances, EHIM, Powered by ProCare Rx, may be permitted a one-time thirty (30)-day extension. I understand and acknowledge the accounting will include: (1) the date of the disclosure; (2) the name and address, if known, of the individual and/or entity who received the PHI; (3) a brief description of the PHI disclosed; and (4) the purpose of the disclosure that reasonably informs the requestor the basis for the disclosure; or, in lieu of such statement, a copy of a written request for a disclosure, if any. I understand and acknowledge that this request for accounting of my PHI will involve time and preparation by EHIM, Powered by ProCare Rx, and that I am allowed one (1) free accounting in a twelve (12)-month period. I also understand and acknowledge that EHIM, Powered by ProCare Rx, reserves the right to charge a reasonable, cost-based fee for each subsequent request for an accounting of disclosures by the same requestor during the same twelve (12)-month period. The information described on this form is protected by law and shall only be used as indicated above, unless otherwise required and/or permitted by law.

Signature:	Date:

If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative signed by the Member naming you as a personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.

Signature of Personal Representative:	Date:

Relationship: ☐ Parent/Legal Guardian ☐ Personal Representative ☐ Other

C. TO BE COMPLETED BY EHIM

☐ Request Approved. Effective Date _____ ☐ Request Denied. Reason _____

☐ Additional Comments

EHIM Representative Signature:	Date:

If you have any questions, please contact the EHIM, Powered by ProCare Rx, Privacy Officer at (800) 311-3446. Please either fax this form to (248) 204-9904 or mail it to EHIM, Powered by ProCare Rx, 26711 Northwestern Hwy, Suite 500, Southfield, MI 48033, Attn: Privacy Officer