REQUEST FOR AN ACCOUNTING OF DISCLOSURES FORM

Date of Request:_____

Member Name: _____ Date of Birth:_____

Member CIN: _____ Telephone Number:_____

I would like a report of how my Protected Health Information (PHI) was disclosed by CalOptima Health, as required by law. I understand that CalOptima Health does not have to tell me about the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment, and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures made prior to April 14, 2003.

I also understand that my right to a report of some, or all disclosures, may be suspended in some instances.

I understand that CalOptima Health must give me the report of disclosures within 60 days of my request or give notice to me that an extra 30 days (or less) is needed to prepare it.

I understand I am allowed 1 free report of disclosures every 12-months. I may be charged a fee if I ask for more than 1 report within the same 12-months.

Please note, this is not a request for Access to Protected Health Information (PHI). You will not get records such as Medical Claims or Pharmacy Claims by using this form. If you would like these types of records, please fill out the Individual Request for Access to Protected Health Information in the Designated Record Set form.

To learn more about your privacy rights, please visit our website at www.caloptima.org or call CalOptima Health's Customer Service Department toll-free at **1-888-587-8088**. Members with hearing or speech impairments can call our TTY at **711**. We have staff who can speak your language.

I would like a record of disclosures that covers the following time period:

From _____ to _____
(mm/dd/yyyy)

Note: The time period may not be longer than six (6) years, and may not include dates before April 14, 2003.

Delivery method requested **(select one):**

☐ "Personal" pick-up at CalOptima Health (ID required at the time of pick-up)

☐ Mail

_____
Address/Unit# City State Zip

☐ Electronically, sent through a secure e-mail to: _____
Email Address

Member Signature: _____ **Date:** _____

If Personal Representative, please complete the section below and provide documentation:

Print Name: _____ **Relationship to Member:** _____