HIPAA DISCLOSURE ACCOUNTING REQUEST

Purpose: This form is for use by the TRICARE beneficiary or the beneficiary's authorized representative to document the beneficiary's request for an accounting of disclosures of his/her protected health information.

SECTION A: BENEFICIARY REQUESTING ACCOUNTING

Name:		
Address:		
Telephone:	( )	E-mail:
Social Security Number:	Sponsor: - -	Beneficiary: - -

You have the right to an accounting of certain disclosures TriWest made of your protected health information. The maximum accounting period is the 6 years prior to your request, except that we are not obligated to account for disclosures made before April 14, 2003. TriWest also does not have to account for the following disclosures made:

- → **for treatment, payment or healthcare operations activities,**
- → **to you, to your personal representative, or pursuant to your authorization or permission,**
- → **as part of a limited data set,**
- → **for national security or intelligence purposes,**
- → **to law enforcement officials or correctional institutions, or**
- → **incidental disclosures permitted by HHS Privacy regulations.**

To exercise your right to request an accounting of disclosures regarding our use or disclosure of your protected health information, please complete SECTION B.

SECTION B: REQUESTED ACCOUNTING OF DISCLOSURES

What period of time are you requesting accounting for? From: ___/___/___ To: ___/___/___

Do you have any specific disclosures of protected health information that you are interested in? If so, please describe.

You are entitled to one free disclosure accounting every 12 months. TriWest will charge you $100.00 for each additional accounting you request during the same 12 month period. You may withdraw your request for additional accountings within 5 working days of the request if you determine you do not wish to pay the service charge.

BENEFICIARY'S SIGNATURE: Date: ___/___/___

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

Relationship to Individual:

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Please submit the completed and signed request to: TriWest Healthcare Alliance; Attn: HIPAA Privacy Official; P.O. Box 42049; Phoenix, AZ 85080-2049