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

Protected Health Information (PHI) is information about your health. This form must be completed and signed to process this request.

1 Who is the ATRIO member?

First name _____ Last name _____ Middle initial _____

Member ID number _____ Birth date (MM/DD/YYYY) _____ Phone number _____

Street _____

City _____ State _____ ZIP code _____

2 About the Accounting Report

- Once we get this signed request form, we will send you the Accounting Report.
- The report lists disclosures of the member's PHI made for reasons other than treatment, payment, or health care operations, and does not include disclosures excluded by law (such as those made to you or that you authorized in writing).
- Your first report in any 12-month period is free. We may charge a reasonable, cost-based fee for another report within 12 months. We will tell you about any fee first, and you may change or withdraw your request.

3 Accounting Report time period

The time period cannot be longer than six (6) years from the request date. My request is for the dates below:

From (MM/DD/YYYY) _____ to To (MM/DD/YYYY) _____

4 Where do you want this Accounting Report to be sent?

Who is receiving this Accounting Report?

☐ Member ☐ Member's legal representative ☐ Member's parent or legal guardian

Print name of recipient _____

Recipient's street address _____

City _____ State _____ ZIP code _____

Important information

- By signing this form, I ask ATRIO Health Plans to give an Accounting of Disclosures of PHI Report about the member named in Section 1 to the recipient named in Section 4.
- This approval is only for this request.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- Disclosures older than six years from when this request was made will not be included.

5 Signature of member or authorized representative

Signature

Date (MM/DD/YYYY)

Print name

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative):

Relationship to member

Authorized representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If you are a representative signing this form, you must send legal proof that you can act for this person.

Please sign and return this completed form to:

Email

Compliance@atriohp.com

Attach this form. Do not include health information in the subject line.

Please allow up to 60 days for our response.

Mail

ATRIO Health Plans
Attn: Compliance – HIPAA Privacy
550 Hawthorne Ave SE, Suite 140
Salem, OR 97301

Questions? We can help. Call ATRIO Customer Service at 1-877-672-8620 (TTY 711).

ATRIO Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Free language assistance and auxiliary aids and services are available. Call the number above.

FOR ATRIO USE ONLY

Date request received

Received by (CSR name)

Call / case reference

Caller name

Caller is

Signature method

☐ Caller identity verified per Customer Service HIPAA verification procedure

☐ Proof of authority received