AmeriHealth Caritas
VIP Care

Request for List of Disclosures of Protected Health Information

Use this form to request an Accounting of Disclosures of your protected health information (PHI).

Section A: Requesting individual
Please complete the following:

Name:		Phone:
Address:		City:
State:	ZIP code:	Member ID number:

Please read and complete the following:
You have the right to an Accounting of Disclosures that we, or our business associates, have made of your PHI in the six years prior to the date of your request. However, we are not required to account for disclosures that were:

- Made to carry out treatment, payment or operations.
- To the patient or the patient's personal representative.
- Incidental disclosures made in connection with a use or disclosure otherwise permitted or required by HIPAA.
- Made to persons involved in a patient's care or as part of an inpatient directory.
- Pursuant to an authorization for release of information signed by the patient or patient's personal representative.
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials under certain circumstances.
- Part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health or certain health care operations purposes.
- Made prior to April 14, 2003.

Section B: Dates of disclosures
Please specify the date range for the Accounting of Disclosures you are requesting:

Start:	End:

You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

Section C: Signature

I request an Accounting of all Disclosures of my PHI as specified above. I understand that I am entitled to one free disclosure accounting every 12 months. I agree to pay a reasonable fee for this accounting if I have already received one within the previous 12 months.

Signature:	Date:

Section D: Personal representative
If you are not the member, please sign and date Section D of this form. Check the box that describes your relationship to the member. **If you are not a parent or legal guardian of the member, please attach proof of your relationship to the member (e.g., power of attorney, personal representative, etc.).**

Print name of personal representative:	
Signature of personal representative:	Date:

☐ Parent or legal guardian ☐ Power of attorney ☐ Executor ☐ Other:_____

Please return this form to: AmeriHealth Caritas VIP Care
Medicare Compliance
3875 West Chester Pike
Newtown Square, PA 19073