REQUEST FOR AN ACCOUNTING OF DISCLOSURES

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: INFORMATION OF MEMBER			
Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone # ( )	Cell Phone # ( )	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date _ _ /_ _/_ _ _ _	

PART B: RECORD DATES

You may request an accounting of disclosure for a maximum period of six years prior to the date of this request.

Please specify the period of time for which you are requesting the information:

From date _ _ /_ _/_ _ _ _ **through date** _ _ /_ _/_ _ _ _

PART C: RECORD FORMAT

Please indicate the format you would like to receive the records in:

☐ **Paper** ☐ **Electronic (encrypted CD or DVD)**

PART D: DELIVERY METHOD

☐ **Pick up all my communications at an HMSA office** (Check one)

HMSA Center (Oahu) Hilo Office Kona Office Maui Office Kauai Office

The records will be available to you for pickup at one of our HMSA Customer Relations offices. You will receive a notification when your records are ready to be picked up, and this notification will provide you with instructions for pick up, and the address and times of operation for our Customer Relations offices. If you or your authorized representative are unable to pick up your copies, then you may authorize another person to do so by completing an authorization form. Please contact HMSA's Customer Relations department at (808) 948-6111 on Oahu to obtain a copy of this form.

☐ **Send Via Certified Mail –** HMSA, upon request, will mail your records to the address on your HMSA account via certified mail.

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PART E: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

- I have the right to an accounting of the disclosures HMSA makes of my protected health information.
- HMSA does not have to account for disclosures it makes (a) to me, to my authorized representative, or pursuant to my authorization or informal permission, (b) as part of a limited data set for research, public health or health care operations activities, (c) for national security or intelligence purposes, (d) to law enforcement or correctional institutions regarding persons in lawful custody, or (e) incidental to an allowable disclosure.
- I may request a copy of this signed form.

PART F: SIGNATURE

I, (print member's name) ________________________________, have had full opportunity to read and understand the contents of this form.

Signature ____ **Date:** _ _ /_ _/_ _ _ _
(Member or Authorized Representative)

If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: ____

Relationship to Member: ____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580