REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Purpose: To request that CareConnect Insurance Company, Inc. ("CareConnect") provides you with an accounting of certain disclosures that it has made of your protected health information ("PHI"). Please refer to CareConnect's Notice of Privacy Practices **or contact CareConnect's Privacy Officer at (516) 405-7514** for information.

Member information requested. (Please Print)

Member's Name:_____

Address:_____

Member Identification Number:_____ Birthdate:_____

Group or Account # on ID card:_____

Phone number where we can reach you to process your request (required): (_____) _____-_____

I would like an accounting of covered disclosures of my PHI made by CareConnect between the following dates: _____ and _____.

Please select one:

☐ I am a Member of CareConnect.

☐ I am the **personal representative** of a Member of CareConnect.
(Please attach proof of personal representative status—*e.g.,* guardianship papers, health care proxy).

Please Read Carefully and Sign Below

I understand that CareConnect will provide the requested accounting of disclosures if required to do so under applicable law. If this is not my first request for an accounting within a 12-month period, I understand that CareConnect will notify me of its reasonable costs for complying with my request and provide me with the opportunity to agree to pay those charges in order to receive the requested accounting.

Please note: Applicable law requires us to respond to you within 60 days after receiving your request, unless we send you a notification that we will need an additional 30 days to respond.

Member Signature

If this request is from the **Member**, please complete the following: I request CareConnect Insurance Company, Inc. (CareConnect) to provide an accounting of my protected health information for the dates specified above.

_____ _____

(Print) (Signature)

Date:_____

Personal Representative Signature

If this request is being made by a legally authorized personal representative on behalf of the Member to account his/her protected health information, please complete the section below and provide documentation of authority to act as the Member's personal representative.

_____ _____

(Print) (Signature)

Relationship to Individual:_____ Date: _____

Personal Representative: If you are not the Member or parent of the minor Member, please attach proof of your relationship to the Member. **We will require verification of the authority** before this request will be considered complete. Please attach copies of your authorization as required by state law to represent the Member - for example, health care proxy or guardianship papers. 45 CFR § 164.502(g)

Please return this completed form by:

Mail to:
CareConnect Insurance Company, Inc.
Attention: Privacy Officer
2200 Northern Boulevard, Suite 104
East Hills, NY 11548

Fax: (516) 706-3829

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.