



## Michigan Conference of Teamsters Welfare Fund Individual Request for Accounting of Disclosures of Protected Health Information

### Section #1: Individual Information

I certify that I am (check all that apply):

- A participant (employee/retiree)
- A participant's spouse or surviving spouse
- A non-spousal dependent of a participant
- A personal representative\*

Name of Participant: \_\_\_\_\_  
(print name)

Participant's Contract Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Participant's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM / DD / YR

You can contact me at:

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

I am requesting an accounting of the disclosures of health information for (check only one):

- Myself (print name) \_\_\_\_\_
- My dependent minor child (print name) \_\_\_\_\_
- A covered individual for whom I am the personal representative\* (print name) \_\_\_\_\_

*\*Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete the personal representative area found in Section #3. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

### Section #2: Request for Accounting of Disclosures

I, \_\_\_\_\_ (print name), hereby request an accounting of the disclosures of the health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the identified individual in Section #1. I understand that the Michigan Conference of Teamsters Welfare Fund (the Fund) does not have to provide an accounting of disclosures related to treatment, payment, health care operations and certain other exceptions as defined by the Privacy Rule. I also understand that the Fund is only obligated to provide such an accounting for up to six years prior to the date of my request. I request that the Fund provide an accounting of disclosures for the following dates:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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I understand that I may receive an accounting of disclosures once during any twelve (12) month period at no charge. If I request more than one accounting of disclosures during any twelve (12) month period, I understand that I will be charged a minimum fee of \$10.00 plus an additional charge for time spent preparing the disclosure.

I, \_\_\_\_\_ (print name), have reviewed this form and understand its contents. By signing this form, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Signature  
Signature MM DD YY

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Section #3: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: \_\_\_\_\_  
(print name)

Name of individual you are representing: \_\_\_\_\_  
(print name)

Relationship to individual or nature of authority (e.g., parent of an unemancipated minor, unlimited guardian pursuant to letters of authority, personal representative pursuant to letters of authority, parent advocate pursuant to a health care power of attorney, other statutory authorization): \_\_\_\_\_

**Note:** You must provide valid and current proof of your legal relationship as a personal representative.

#### Personal Representative Contact Information

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Signature  
Signature of Personal Representative MM DD YY

### Section #4: Submission Instructions

Submit Form to: Privacy Officer  
Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, MI 48216