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

Section #1: Individual Information

Name _____ Birth Date _____/_____/_____
Please Print MM / DD / YR

Contract Number _____ or Social Security Number _____
(Found on ID card)

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ E-mail _____

Section #2: Request for Accounting of Disclosures

I 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:

_____

_____

_____

_____

_____

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.

Section #3: Authorization and Signature

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 / YR

Address_____

City _____ State _____ ZIP Code _____

☐ I am the personal representative for the member.*
**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete Section #4. 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 #4: 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., health care power of attorney, guardian, other statutory authorization):

_____*Note: If other than natural parent of a minor child, valid and current proof of legal relationship as personal representative must be provided.*

Personal Representative Contact Information

Address: _____ Telephone Number: _____

_____ E-mail: _____

_____ Date of Signature _____/_____/_____
Signature of Personal Representative MM / DD / YR

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

Or Fax to: ***313-496-2943***