MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS

PARTICIPANT'S REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Participant Name:_____ Social Security Number: _____

Address: _____

_____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____ Participant Birth Date: _____

I am requesting an accounting of disclosures of my protected 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).

The MPI Health Plan does not provide an accounting of disclosures made for the following purposes:

- pursuant to an authorization the individual has signed;
- that are incidental to another permissible use or disclosure;
- that are part of a limited data set;
- made for the purposes of payment or health care operations, including those made to business associates;
- made to the individual who is the subject of the information;
- made for national security or intelligence purposes;
- made to correctional institutions or law enforcement officials; and
- made prior to April 14, 2003 (the compliance date of the Privacy Rule)

By signing this form, I am confirming that it accurately reflects my wishes.

_____ ____/____/____
Participant Signature *Date*

If this Request for an Accounting is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the MPI Health Plan.

If signed by personal representative, name of personal representative: _____

Relationship to Participant or nature of authority:_____

_____ ____/____/____
Signature of Personal Representative *Date*

THIS REQUEST MUST BE COMPLETED IN FULL BEFORE BEING SUBMITTED

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