# REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Health Plan of San Joaquin | Mountain Valley Health Plan

The Health Insurance Portability and Accountability Act gives you the right to request an accounting of how we shared your health information. Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") will tell you who we shared your information with, when and why we shared it, and what health information we shared.

The Health Plan does not have to tell you about information we gave you or someone helping to care for you, or that you gave us permission to share. We also do not have to tell you about information we shared to arrange for your treatment, payment of claims, or health care operations. For a description of these activities, please read the Notice of Privacy Practices. If you need another copy of the Notice, call the Member Services department at **1-209-942-6320** or go to our website at **www.hpsj-mvhp.org**.

You must complete the entire form. Once the form is completed, you may mail or bring it to the following address:

**Health Plan of San Joaquin/Mountain Valley Health Plan**
**7751 South Manthey Road**
**French Camp, CA 95231-9802**

You may also fax the form to: **1-209-461-2550** or send to Health Plan through a secured email.

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Please tell us what period you want an accounting? (Note, the period may not be longer than six years and may not include dates before April 14, 2003.)

| **Beginning Date (MM/DD/YY):** |
|---|
| **End Date (MM/DD/YY):** |

If the Health Plan accepts your request, we will give you the accounting within 60 days after receiving your request. If more time is needed, we will notify you. If the Health Plan has to deny your request, you will be notified of the reason within 60 days after receiving your request.

You may get one accounting every 12 months for free. For additional accountings, the Health Plan may charge you for the cost of copying and mailing. The cost for copies is .25 cents for each page. The cost of mailing depends on how many pages are sent. If you are asking for additional accountings, do you agree to pay these fees? ☐ Yes ☐ No

| **Name of Member:** | |
|---|---|
| **Health Plan ID Number:** | **Telephone Number:** |

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**Signature of Member or Personal Representative**  **Date**

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Note, if you are acting as the Personal Representative of a member, please tell us your relationship to the member:

**Relationship to the Member**

You may be required to show us proof of your legal permission to receive an accounting of how we shared the member's health information.

Should you have questions about this form, please contact the Member Services department at **1-209-942-6320**.