



# Request for an Accounting of Disclosures of Protected Health Information

## Information Identifying the Individual Whose Records Are Being Requested

Name of Individual: \_\_\_\_\_ SSN: \_\_\_\_\_

Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes. If provided, the Agency will use your information for purposes of finding the requested information.

Medicaid ID or Gold Card Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Information Identifying the Time Period Requested

Provide the *specific* dates requested.

From Date: \_\_\_\_\_ To Date: \_\_\_\_\_

**I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Legal Authority if Other Than Individual: \_\_\_\_\_

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).



# Request for an Accounting of Disclosures of Protected Health Information

## Your Right to an Accounting of Disclosures

You have a right to request an accounting of certain disclosures of the protected health information about you that the Agency for Health Care Administration has in its records.

You may submit your request directly to the Privacy Officer at the address given at the bottom of this page or to your Field Office, which will forward it to the Privacy Officer.

Your right to an accounting of disclosures does not include: Disclosures for the purpose of treatment, payment and health care operations; Disclosures made to you of your own protected health information; Disclosures that were incidental to a use or disclosure that is otherwise permitted or required by the Health Insurance Portability and Accountability Act (HIPAA); Disclosures that you authorized be made; Disclosures made to individuals involved in your care or for disaster relief purposes; Disclosures for national security or intelligence purposes; Disclosures to correctional institutions or law enforcement officers, for a limited period of time if requested by the institution or law enforcement officer; Disclosures that are part of a limited data set; Disclosures made more than 6 years prior to your request for an accounting of disclosures.

You have a right to receive a list of disclosures within 60 days from the date that the Agency receives your request. If the information is not accessible (for example, the information has been put in storage) and there will be a delay in getting you the information, you will be told the reason for the delay and the date when you will receive your information. The delay cannot be for more than 30 days.

Your first request for an accounting of disclosures in a twelve-month period is free. You may be charged a fee to cover the expense of producing, copying and mailing the information for an additional request within the same twelve-month period. You will be notified of the amount of the expense in advance.

If you have any questions about requesting an accounting of disclosures of your protected health information, call or write to:

**Privacy Officer**  
**Agency for Health Care Administration**  
**2727 Mahan Drive, Mail Stop #4**  
**Tallahassee, Florida 32308**  
**Phone: 850-412-3960 FAX: 850-414-6837**  
**[HIPAAComplianceOffice@AHCA.MyFlorida.com](mailto:HIPAAComplianceOffice@AHCA.MyFlorida.com)**