



# ACCOUNTING OF DISCLOSURES REQUEST FORM

Complete this form and return to: Privacy Compliance Administrator,  
Corporate Compliance, Capital District Physicians' Health Plan, Inc.,  
500 Patroon Creek Blvd., Albany, New York 12206-1057

## I. MEMBER INFORMATION

Date of request: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

CDPHP Identification #: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

## II. DATES REQUESTED

I would like an accounting of all reportable disclosures for the following time frame. *Please note: CDPHP is not required to account for disclosures that occurred before April 14, 2003.*

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

## III. INFORMATION REQUESTED

Select one of the following:

I wish to receive an accounting of all reportable disclosures

I wish to receive an accounting of all reportable disclosures related to:  
*(Please specify: For example, disclosures related to a type of injury or benefit.)*

## IV. ADDRESS INFORMATION

Indicate the address where the information should be sent:

## V. SIGNATURE

I am requesting the information noted above in my capacity as *(select one)*:

Self       Parent       Guardian       Legal Representative *(attach signed authorization form)*

Other (explain): \_\_\_\_\_

Signature of member  
or legal representative \_\_\_\_\_ Date \_\_\_\_\_