



## Community Health Plan of Washington Request for an Accounting of Disclosures

Use this form to request a list of the times over the past six years when Community Health Plan of Washington (CHPW) shared your protected health information (PHI) with another person or organization. This includes the times CHPW shared your PHI outside of disclosures allowed by law.

1. **Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Member ID Number:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

**Member Address:** \_\_\_\_\_

**Member email:** \_\_\_\_\_

**Member Phone:** \_\_\_\_\_ **Member Fax:** \_\_\_\_\_

**Choose one:**  Ok to leave message with detailed information.  
 Leave message with call-back number only.

2. I would like an accounting of disclosures for the following timeframe (e.g., From: 01/01/2015 To: 01/01/2020).

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

If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/organization, please describe the disclosures for which you are seeking an accounting:

\_\_\_\_\_

3. I understand that the accounting of disclosures will be provided to me within 60 days of the date of this request, unless CHPW extends the timeframe for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive the accounting.

\_\_\_\_\_  
**Printed Name** **Phone** **Date**

\_\_\_\_\_  
**Signature**



Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

**Telephone Number of Personal Representative:** \_\_\_\_\_

**Personal Representative's relationship to the member:** \_\_\_\_\_

**4. Send the completed, signed request to:**

Community Health Plan of Washington  
 Attn: Customer Service Department  
 1111 3<sup>rd</sup> Ave, Ste. 400  
 Seattle, WA 98101  
 Fax: (206) 521-8834  
 Email: [CustomerCare@chpw.org](mailto:CustomerCare@chpw.org)

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

<p><b>If you are a Washington Apple Health (Medicaid) Member</b></p> <p>Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://www.chpw.org/for-members/your-privacy-and-rights/">https://www.chpw.org/for-members/your-privacy-and-rights/</a></p>	<p><b>If you are a CHPW Medicare Advantage Member</b></p> <p>Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://medicare.chpw.org/member-center/member-rights/">https://medicare.chpw.org/member-center/member-rights/</a></p>
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