TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

DISCLOSURE ACCOUNTING REQUEST

Purpose: This form is used to document an individual's request for an accounting of disclosures of protected health information.

SECTION A: Individual requesting disclosure accounting.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to an accounting of the disclosures we make of your protected health information. The maximum accounting period is the 6 years prior to your request, except we are not obligated to account for disclosures made before April 14, 2003. We also do not have to account for disclosures we make (a) for treatment, payment, or health care operations activities, (b) to you, to your personal representative, or pursuant to your authorization or informal permission, (c) as part of a limited data set for research, public health or health care operations activities, (d) for national security or intelligence purposes, or to law enforcement or correctional institutions regarding persons in lawful custody, or (e) incidental to an allowable disclosure. To exercise your right to a disclosure accounting, please complete Section B.

SECTION B: Disclosure accounting requested.

Please specify the accounting period: From: ____/____/____ To: ____/____/____

You are entitled to one free disclosure accounting each 12 months. TRIPLE-S SALUD may charge $0.75 per page for each additional disclosure accounting you request in the same 12 month period.

INDIVIDUAL'S SIGNATURE – You are entitled to a copy of this request

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____