



Disclosure Accounting Request

Member Information

(Please Print)

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Date: _____	Member ID: _____
Name: _____	Date of Birth: _____
Address: _____	Telephone: _____
_____	Email: _____

You have the right to an accounting of the disclosures Davis Vision or its business associates have made of your protected health information (a) without your permission (whether informal agreement or signed authorization) as allowed by law, (b) to the Department of Health and Human Services for privacy compliance purposes, or (c) pursuant to an express legal permission Davis Vision obtained before April 14, 2003. The accounting period is the 6 years prior to your request, except you are not entitled to an accounting of any disclosures made before April 14, 2003, which is our compliance date under the federal privacy rules. You are also not entitled to an accounting for disclosures Davis Vision or its business associates (a) made for purposes of your treatment, to obtain payment for that treatment, or for health care operations (including certain disclosures for the payment or operations of others), (b) to you or to your personal representative, (c) made pursuant to your authorization or informal agreement, (d) as part of a limited data set, (e) made incidental to an allowable disclosure, or (f) for national security or intelligence purposes, or to certain law enforcement agencies. You are entitled to one free disclosure accounting each 12 months. We will charge you a cost based amount for each additional disclosure accounting you request during the same 12-month period.

To request the accounting of disclosures, complete and mail or fax this request to:

Davis Vision – Privacy Office
P.O. Box 1416
Latham, NY 12110-1416
Fax: 1-866-999-4640

If you have questions, need additional information or assistance in completing your request, please contact the Davis Vision Privacy Office at 1-800-571-3366 or the address shown above.

I request an accounting of the accountable disclosures of my protected health information made within the 6 years prior the date of this request (except not earlier than your compliance date under the federal privacy rules). I understand that I am entitled to one free disclosure accounting each 12 months.

Signature: _____ **Date:** _____
(Person Granting Authorization)

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

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

PLEASE RETAIN A COPY OF THIS DISCLOSURE ACCOUNTING REQUEST FOR YOUR RECORDS