

## Request for an **Accounting of Disclosures of Protected Health Information (PHI)**

Member's name	Date	Date	
Member's date of birth	Member's Socia	Member's Social Security Number	
Requestor's name  Member's or Requestor's signature (if different from Member)		1	
You or your authorized representative submitting this form. A decision regar law. MBHP will give you a list of disclolaw. This includes disclosures made to authorities or correctional institutions. 2003, those that were approved by yo healthcare operations. Disclosures me excluded.  Period of time to be reported:	ding the request will be mossures it has made except to you, to persons involved in Also excluded are disclosul, and those that are related	ade within time frames specified by for those that can be excluded by n your care, and to some legal ures that were made before April 14 ed to treatment, payment, and	
Address to which the report should be	be sent:		
Street			
City	State	Zip	
If you are requesting access to inform authority to do so (for example, Guard			
Mail this form to:  MBHP, Attention P 200 State Street, S Boston, MA 02109 Fax number: (877)	Suite 305		

MBHP complies with applicable federal civil rights laws and does not discriminate, exclude, or treat people differently because of race, color, national origin, ancestry, age, disability, religious creed, sex, sexual orientation, gender identity, gender stereotyping, genetic information, or veteran status. MBHP's notice of non-discrimination can be found at

http://www.masspartnership.com/member/NonDiscriminationNotice.aspx.

## You can get this information in other languages and other formats, such as large print or Braille.

Call us at 1-800-495-0086 from Monday to Thursday, 8 a.m. to 5 p.m. and Friday 9:30 a.m. to 5 p.m. The call is free! Call TTY 1-877-509-6981 if you are deaf, hard of hearing, or speech impaired.

Tenemos información en espanol. Servicio de interpretes gratis!