



**The Member's Request for an Accounting of Disclosed Protected Health Information**

This is the form that you asked Community Care to send to you.

You need to fill out this form, sign your name, write the date on the form, and mail it to the address below.

**Community Care Behavioral Health Organization  
Privacy Officer  
One Chatham Center, Suite 700  
Pittsburgh, PA 15219**

Please remember Community Care does not maintain medical records. You must contact your doctor or the hospital where you were treated for your medical records.

Community Care will review the information, and will send you a written response.

**Please print and use a pen to fill in the form.**

<b>Your Name:</b>			
<b>Your Address:</b>			
<b>Your Date of Birth:</b>		<b>Your Social Security Number:</b>	
<b>Your Phone Number:</b>		<b>Please write down your phone number in case we need to call you.</b>	

**1. Please write what information you want an accounting of disclosures for, on the lines below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Please enter the date(s) on the line(s) below, for when you want the accounting of disclosures:**

\_\_\_\_\_  
\_\_\_\_\_

**3. You need to sign your name and write the date on the lines below:**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**4. If you are a minor, please write in who your guardian is:**

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

Address: \_\_\_\_\_

**If you have any questions about this form, please call the Member Services Number at 1-866-473-5862.**

**Please do not write on these lines.**  
**Date Received: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_ Response Sent: \_\_\_\_\_**