

SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way

Camp Springs, Maryland 20746

1 (800) 252-4674

**REQUEST FOR AN ACCOUNTING OF DISCLOSURES
OF PROTECTED HEALTH INFORMATION**

Participant Name: _____ Date of Birth: ____/____/____

Address: _____

Daytime Phone Number: _____

Evening Phone Number: _____ Social Security Number: _____

I am requesting an accounting of disclosures of my protected health information for the following period: date from _____ date to _____.

I understand that the Plan cannot provide me with an accounting of disclosures that occurred before April 14, 2003. I also understand that the Plan cannot provide me with an accounting of disclosures for periods of more than six (6) years. I further understand that the Plan will provide the first accounting I request during any 12-month period without charge, but that I may be charged a fee for more frequent accountings.

Signature of Participant: _____ Date ____/____/____

If signed by personal representative:

Name of personal representative: _____

Relationship to participant or nature of authority: _____

Signature of Personal Representative _____ /____/____
Date