SEAFARERS HEALTH AND BENEFITS PLAN

5201 Capital Gateway Drive
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

Social Security # _____

Address: _____

_____

_____

Daytime Phone Number: _____ Evening Phone Number: _____

I am requesting an accounting of disclosures of my protected health information for the following period:

From Date _____ To Date _____

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