Part I - Request for Accounting of Non-Routine Disclosures of Personal Health Plan Information

Form Received By | Date

Check One:
☐ Allied Pilots Association Voluntary Supplemental Medical & Custodial Care Benefit Plan (the "Plan")
☐ Allied Pilots Association Catastrophic Major Medical Benefit Plan (the "Plan")
☐ Allied Pilots Association Employee Health Benefit Plan (the "Plan")

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations as described in more detail in the Plan's Privacy Notice.

1. Member or Employee Name:	1a. Member or Employee Number:
1b. Member or Employee Date of Birth:	1c. Your Name:
2. Name of Person Whose Accounting You Are Requesting:	2a. Relationship to Member or Employee: Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Address:	3a. Your Relationship to Person in Box 2: Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ Other (please describe relationship):

I understand that I can request an accounting of non-routine disclosures of personal health plan information once within any twelve (12)-month period, free of charge. If I request accountings more frequently, I understand the Plan will charge me a reasonable, cost-based fee for each subsequent request.

The accounting of non-routines disclosures of PHI will include the following information:

- The date of disclosure;
- The name of the person or entity to whom information was made and the person's or entity's address (if known);
- A brief description of the information disclosed; and
- The reason for the disclosure.

I hereby request an accounting of any non-routine disclosures of personal health plan information of the person named in Box 2 made by the Plan for the following time period ____________________________ **[Enter time period (disclosures can be requested for a time period of up six (6) years, beginning no earlier than April 14, 2004)].**

Please return completed form to:

HIPAA Privacy Official
Allied Pilots Association
14600 Trinity Blvd., Suite 500
Fort Worth, TX 76155
Fax 817-302-2146

Signature | Date

Part II - Determination of Request for Accounting of Non-Routine Disclosures of Personal Health Plan Information

Form Part II Prepared By | Date

After reviewing your request for an accounting of non-routine disclosures of personal health plan information, the Plan has made the following determination:

☐ Request Approved without a fee (see section A) ☐ Request Approved with a fee (see section B) ☐ Request Denied (see section C)

Section A: Request Approved without a Fee

Your request for an accounting of non-routine disclosures of personal health plan information is approved.
Your requested accounting of disclosures is attached to this form. There is no charge for processing request.

Section B: Request Approved with a Fee

Your request for an accounting of non-routine disclosures of personal health plan information is approved.
You requested and received an accounting of non-routine disclosures of personal health plan information, free of charge on __________.
You have the right to withdraw or modify your request for an accounting. Unless you contact the HIPAA Privacy Official at the following address, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, 76155 or by fax to 817-302-2146 within 10 days from____________to withdraw or modify your request, the HPAA Privacy Official will mail you your requested accounting

Section C: Request Denied

Your request for an accounting of non-routine disclosures of personal health plan information is denied because none of your PHI was disclosed for a non-routine purpose.
If you wish to make a complaint, please contact the Plans' HIPAA Privacy Official at 800-323-1470 x 2145.

Name of Plan Representative | Signature of Plan Representative | Date of Determination