

MphasiS Employee Health and Welfare Benefit Plan

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Name: _____

SSNO: _____

I hereby request an accounting of disclosures of my "Protected Health Information" ("PHI") maintained about me by the MphasiS Employee Health and Welfare Benefit Plan (the "Plan"), pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Please Complete The Items Below:

Period For Which Request Is Applicable: _____

By your signature below, you signify your assent to the following:

- I understand the Plan is not required to provide an accounting of disclosures made: 1) to me; 2) to carry out treatment, payment or health care operations; 3) incident to a use or disclosure otherwise permitted or required by HIPAA; 4) pursuant to an individual authorization; 5) to certain persons involved in my care or payment for that care or to notify certain persons of my location, general condition, or death, or to assist in disaster relief efforts; 6) for specific national security or intelligence purposes; 7) to correctional institutions or law enforcement when the disclosure was permitted without authorization; 8) as part of a limited data set as defined under HIPAA; or 9) prior to the compliance date of November 20th 2013
- The accounting will include disclosures of PHI that occurred only during the 6-year period prior to the date of this request, and that occurred after November 20th 2013
- The Plan has 60 days to respond to this request. If additional time is necessary, the Plan may extend this period for an additional 30 days provided I am given written notice of the extension, prior to the expiration of the initial period, including the reason for the delay.
- If this request is for a second or subsequent accounting within a 12-month period, the Plan may charge me a reasonable, cost based fee for the accounting.

Date

Signature of Participant