ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES REQUEST FORM

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), an individual has the right to request an accounting of disclosures of the individual's personal health information ("PHI"). Such accounting of disclosures requires the Kenton County Airport Board ("Board"), as a Covered Entity, to provide the requesting individual a list of certain disclosures of PHI that were made by the Board. Generally, you may receive an accounting of disclosures that are either required by law or made in connection with public health activities or in similar situations. You do not have a right to an accounting of certain other types of disclosures, as described below. You may request an accounting of disclosures covering up to three years if your PHI is held in electronic format, and six years if the information is not held in an electronic health record.

By signing below, you hereby acknowledge that:

You understand that you are requesting an accounting of all disclosures of the PHI in your designated record set, EXCEPT for disclosures:

- Required to carry out treatment, payment, or health care operations (unless the information is held in electronic format, as indicated below);
- Covering a period that exceeds six years from the date of the request (unless the information is held in electronic format, as indicated below);
- To you of your own PHI;
- Pursuant to the authorization;
- Incident to a use or disclosure permitted by the HIPAA Policies and Procedures or HIPAA privacy regulations;
- To persons involved in your care or a facility directory;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officials;
- That are part of a limited data set; and
- That occurred before April 13, 2003.

You are hereby notified that your first request for accounting provided by the Board within a twelve (12) month period is free of charge. However, the Board may charge you a fee for any additional accountings provided during that period. You will be notified of any charge in advance and will be permitted to withdraw your request.

You understand that the Board has 60 days after receiving this request to provide you the requested accounting. If the Board cannot provide the accounting within that 60 day time period, the Board may extend the time for furnishing you an accounting by up to 30 days if it provides you a written statement of the reasons for its delay, within the initial 60 day period, and informs you of the date by which it will provide you the accounting.

INFORMATION HELD IN AN ELECTRONIC HEALTH RECORD

By signing below, you further acknowledge that:

You understand that you are requesting an accounting of disclosures of any electronic health record related to your protected health information, provided that your request does not cover a time period that exceeds three years from the date of the request.

NOTE: You cannot request an accounting of disclosures of information held in an electronic health record that were made:

- Before January 1, 2014, if the electronic health record existed on January 1, 2009
- Before January 1, 2011, if the electronic health record was created after January 1, 2009

Individual Information

Last Name	First Name	Middle Initial

I.D. Number (If Applicable)	Social Security Number	Birth Date (MM/DD/YYYY)

Street Address	City, State and Zip Code

Daytime Telephone Number (include area code)

Please indicate what Covered Components or Departments you seek information from:

☐ Health Care Plan	☐ Airport Rescue & Fire Fighting
☐ Finance	☐ Human Resources
☐ Information Technology	☐ Business Administration
☐ Internal Audit	☐ Safety Council

Accounting Information

Upon receipt of this signed Accounting of PHI Disclosures Request Form, the Board will provide you with the requested information within their possession for the last 12 months. If instead of the most recent 12 months of data, you need PHI to include date from a different period, please indicate the data range below:

From: _____ To: _____

Signature of Individual	Date
Printed Name of Individual	
Individual's Street Address	City, State and Zip Code
Signature of Individual's Legal Representative (if applicable)	Date
Printed Name of Individual's Legal Representative (if applicable)	

If this request is signed by the Individual's Legal Representative, you must furnish a copy of the health care power of attorney or other relevant document legally authorizing the Legal Representative to act on behalf of the Individual, as applicable.

Return this completed form to:

Kenton County Airport Board
Scott Gibbons
Vice President Business Administration
P.O. Box 752000
Cincinnati, Ohio 45275-2000
Facsimile: 859-767-7813