SAN FRANCISCO HEALTH PLAN
Here for you

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Date of Request:	
Member First Name:	Member Last Name:
SFHP ID Number:	Date of Birth:
Member Mailing Address:	
The information is to be disclosed by: San Francisco Health Plan P.O. Box 194247 San Francisco, CA 94119	
I would like an accounting of disclosures for the following time frame:	
From:	To:
If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/organization, please describe the disclosures for which you are seeking an accounting:	
I understand that the accounting will be provided to me within 60 days of the date of this request, unless SFHP extends the time frame for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive the accounting. I authorize SFHP to call me if there are questions about this request.	
Signature of Patient or Personal Representative *(If Personal Representative, state relationship to patient):*	Date:
Phone Number:	

FOR SFHP USE ONLY	
Date Received:	Date Sent:
Name of SFHP Employee Processing Request:	Title:

If you are hearing impaired, please call the TDD/TTY line at **1(415) 547-7830,** toll-free at **1(888) 883-7347** or through the California Relay Service at **711.** You may request this document in alternative formats like Braille, large size print, and audio. To request other formats, or for help with reading this document and other SFHP materials, please call Customer Service at **1(415) 547-7800** or toll-free at **1(800) 288-5555.**