IOWA Health and Human Services

# Request for List of Disclosures

| Name of Client | Date of Request |
|---|---|
| Mailing Address – Street or P.O. Box | State ID |

| City, State, and Zip Code | Phone Number | Date of Birth |
|---|---|---|
| | | |

| Email Address | Preferred Method of Communication<br>☐ Email ☐ Mail ☐ Phone |
|---|---|

Check all the programs that apply:

☐ Medicaid ☐ Hawki ☐ Woodward Resource Center

☐ Cherokee Mental Health Institute ☐ Independence Mental Health Institute

**To be completed by client or client's personal representative**

I request a list of the disclosures the Iowa Department of Health and Human Services has made of protected health information for the following family members.

I understand that there may be a charge for this list and that I will be informed of the charge before I receive the list. I will receive this information within 60 days unless I am notified in writing that an additional 30 days is needed to obtain the information.

I understand this list will include the date of the disclosure, the name and address (if known) of the person or agency who received the information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure.

I understand that if my request is denied for any reason, I can appeal the decision. Appeal directions will be provided to me in the decision documentation I receive.

| Name of Individual | State ID | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

I want this information for the following time period (cannot be before April 14, 2003):

From: _____ To: _____

| Client or Personal Representative Signature | Date |
|---|---|
| Representative Printed Name | Relationship to Client |

**To be completed by Privacy Officer**

☐ Request is granted.

☐ Request is denied. Reason for denial: _____

Manual and Rule Reference:

| Privacy Officer Signature | Date |
|---|---|
| | |