



HIPAA Privacy Form Instructions

HIPAA Privacy Form for:

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Salaried Employees
and
- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Hourly Employees

The above mentioned plans are referred to as the "Plan" on the form.

For definition of "Terms" refer to the Privacy Notice which can be viewed on the CITGO intranet or internet Web sites.

**Note: Forms CANNOT be submitted electronically.
Forms must be printed and completed**

Completed forms may be submitted via regular mail to:

CITGO Petroleum Corporation
Benefits Department: N5069
HIPAA Services Contact
P.O. Box 4689
Houston, Texas 77210-4689

or

Completed forms may be submitted via fax to 832-486-1842.

CITGO Petroleum Corporation

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

Form Received By _____

Date _____

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. **Please print, complete and return this form by regular mail or fax.**

1. Employee/Retiree Name	1a. Employee/Retiree Health Plan ID Number or SSN
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Accounting You Are Requesting for Accounting of Non-Routine Disclosures	2a. Relationship to Employee/Retiree Employee Spouse Child Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Your Name (If not Employee/Retiree)	3a. Your Relationship to Person in Box 2 Self Spouse Parent Child <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (please describe relationship): _____
4. Mailing Address for Records	4a. City, State, Zip Code

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-routine 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, 2003)].

Signature _____

Date _____