Pacific Gas and Electric Company

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 Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plan") has made of your protected health information (PHI). 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 Privacy Notice.

1. Employee/Retiree Name	**1a. Employee/Retiree PERNO**
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Accounting You Are Requesting	**2a. Relationship to Employee** Self ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name	**3a. Your Relationship to Person in Box 2** Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ **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 PHI once within any twelve (12)-month period, free of charge. If I request accountings more frequently, I understand the Health Plan will charge me a reasonable, cost-based fee for each subsequent request.

The accounting of non-routines 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 PHI of the person named in Box 2 made by the Health Plan for the following time period _____ **[Enter time period (disclosures can be requested for a time period of up six (6) years)].**

Signature **Date**

Please return completed form to: PG&E HIPAA Administrator, PG&E Benefits Department, 245 Market Street, Mailcode N2T, San Francisco, CA 94105.