

**REQUEST FOR ACCOUNTING OF PLAN'S DISCLOSURES  
OF PROTECTED HEALTH INFORMATION (PHI)**

*HIPAA Privacy Policy Form – For PHI Related to MPC Benefit Plans*

Please complete the following information about the person whose PHI is subject to this request and the plan the request applies to:

Member Name (Please print) \_\_\_\_\_ SSN or Employee ID # \_\_\_\_\_

Patient Name (please print) and SSN \_\_\_\_\_ Relationship to Member \_\_\_\_\_

Street Address \_\_\_\_\_ (City, ST, ZIP Code) \_\_\_\_\_ Email Address \_\_\_\_\_

Primary Contact Number \_\_\_\_\_ Best Time to be Contacted \_\_\_\_\_

I am requesting that I be provided an accounting of the disclosures of PHI for the above noted individual during the time period starting \_\_\_\_\_ and ending \_\_\_\_\_.

**Please describe the specific PHI you are requesting disclosure of and which Marathon Petroleum benefit plan for which the request is applicable:** *(Health Plan, Retiree Health Plan, Dental Plan, Pre-65 Retiree Dental Plan, Vision Plan, Pre-65 Retiree Vision Plan, Employee Assistance Program, Health Care Flexible Spending Account Plan, or Exchange Health Reimbursement Account Plan)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the accounting will not include disclosures for which an accounting is not required under the HIPAA privacy rules. I also understand that where the Plan provides an accounting to me, it will provide it once free of charge within a (12) month period. Any additional request for an accounting within the twelve (12) month period will be subject to a reasonable cost based fee.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HIPAA Privacy Officer Comments:**

- Accept this request.
- Reject this request. Reason: \_\_\_\_\_
- Individual contacted.

**Return completed form to:** MPC Benefits  
Attn: HIPAA Privacy Officer  
539 South Main Street  
Findlay, OH 45840  
[privacy@marathonpetroleum.com](mailto:privacy@marathonpetroleum.com)