

## Request For Accounting Disclosures of Protected Health Information

PATIENT INFORMATION:		
Last Name:	First Name:	
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

By signing below, I am requesting an accounting disclosure of health information for the following period: From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Start Date End Date

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive or release my accounting disclosures, including the following:

\_\_\_\_\_

**Name of Clinic**

I understand that this accounting for disclosures will include disclosures made only to those organizations or persons other than:

♦ Those occurring prior to April 14, 2003.	♦ For national security or intelligence purpose.
♦ To myself or persons involved in my care.	♦ Pursuant to my authorization.
♦ To correctional institutions or law enforcement officials under certain circumstances.	♦ Those exceeding a period of six years prior to the date of this request.
♦ Those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out your operation.	

I understand that my request for an accounting of disclosures will be processed within 60 days of submitting this form. I will be notified of the need for an extension of not more than 30 days to process the request, the reasons for the delay and the date when I can expect to receive the requested accounting.

Please send this accounting by:

- Paper copy    
  Call at number above to pick up    
  Mail to address above  
 CD (must call for password)  
 \*Email: \_\_\_\_\_

\*All emails are routinely sent encrypted, however, I understand that records sent through email poses a security risk and that is my requested method of receipt. (Please Initial) \_\_\_\_\_

## Request For Accounting Disclosures of Protected Health Information

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
\*Name of Interpreter/Translator (if required)

\_\_\_\_\_  
Phone Number

**\*If a translator or interpreter was required.**

### OFFICE USE ONLY

#### Notice of Decision

**Request is:**       Approved/Completed

Denied

#### Reason for denial:

Disclosures occurred prior to April 14, 2003.

Disclosure exceeds more than a six-year period.

No disclosures made for reasons other than those permitted as listed above.

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Office Personnel (Print Name)

\_\_\_\_\_  
Date Request was Processed

\_\_\_\_\_  
Office Personnel Signature