Request For Accounting of Disclosure of Protected Health Information

NOTE: Complete One Form Per Patient

PATIENT INFORMATION:

Name	**Date of Birth**
Street Address	
Email Address	**Phone Number**

Information to be disclosed by:

Facility Name: _____

Facility Phone Number: _____

Facility Address: _____

1. **Time frame of accounting of disclosure of your medical records:**
   Note: The time frame must be no longer than six years and may not include dates before April 14. 2003)

   DATES: (REQUIRED) _____/_____/_____ To _____/_____/_____

2. **If you are seeking for certain type(s) of disclosure of your medical records to a specific individual or organization, please provide additional information of the disclosure you are requesting accounting:**

   _____

   _____

   _____

Signature of Legal Representative/Patient 18 yrs or older	**Date**
Printed name of Legal Representative/Patient 18 yrs or older	**Relationship to Patient**

Note: The Privacy Rule does not require accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to the individual or the individual's personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. You will receive a written response within 60 days of receipt of this request and the practice may request in writing an additional 30 extension as permitted under federal law.