**REQUEST FOR AN ACCOUNTING OF DISCLOSURES**

**OF PROTECTED HEALTH INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like an accounting of disclosures of my Protected Health Information (PHI) made from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the first accounting in any 12 month period will be provided without charge.

I understand that [COVERED ENTITY] may impose a reasonable, cost-based fee for each subsequent request for an accounting made within the 12 month period, provided [COVERED ENTITY] provides advance notice of the fee and an opportunity to withdraw or modify the request for a subsequent accounting.

I understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

I understand that, by law, [COVERED ENTITY] is not required to account for disclosures that occurred prior to April 13, 2003.

I understand that, by law, [COVERED ENTITY] is not required to account for disclosures that were:

* Made to me;
* Necessary to carry out treatment, payment, and health care operations;
* Pursuant to a signed authorization by me or my personal representative;
* For [COVERED ENTITY]’s directory or to persons involved in the patient’s care or other notification purposes;
* For national security or intelligence purposes; or
* To a correctional institution or law enforcement official.

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Signature of Patient or Personal representative Date

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Signature of Privacy Officer Date