REQUEST FOR ACCOUNTING OF DISCLOSURES

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Patients may request an Accounting of Disclosures that lists disclosures of medical information about them that were not for treatment, payment or health care operations and of which they were not previously aware. To request an Accounting, please complete this form and return to the receptionist.

Patient Information:

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Telephone Number: _____ Work Number: _____

Dates Requested:

I would like an Accounting of Disclosures for the following time frame:
(Please note: the maximum time frame that can be requested is six (6) years prior to the date of request, but not before 04/13/2003)

From: _____ To: _____

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Note that no accounting request will be processed unless you or your authorized representatives have signed this form.

If you are an authorized representative (other than the parent of a minor), you will need to provide documentation or an explanation of your authority to act for the patient (e.g. Power of Attorney).

Office Use Only:

Date received: _____ Date Sent: _____

Extension Requested: ☐ No ☐ Yes, Reason _____

Patient Notified on this Date: _____

Staff Member Processing Request: _____