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Request for Accounting of Disclosures of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request an accounting of disclosures by this medical practice and our business associates of health information that pertains to you. This accounting must be provided within sixty (60) days unless this medical practice notifies you that it needs an extension of up to thirty (30) days. The first accounting in any twelve (12) month period is free, but you will be charged a fee for additional accountings based on our reasonable costs to prepare them.

I, ____________________ (*print name*) request an accounting of disclosures of my protected health information that have occurred on/or after April 14, 2003. This accounting should cover the following time period: ________________________________ (*The time period maybe no longer than six (6) years, and may not start earlier than April 14, 2003.*)

I understand this accounting will not include the following types of disclosures which are excluded by law:

1. Disclosures for purposes of treatment, payment or health care operations;
2. Disclosures to me or pursuant to an authorization I have signed;
3. Disclosures to people involved in my care;
4. Disclosures for national security or intelligence purposes;
5. Disclosures to correctional institutions or law enforcement officials if I am in their lawful custody;
6. Disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing me with an accounting of those disclosures would be reasonably likely to impede the agency's or official's activities;
7. Disclosures of information which excludes direct identifiers for purposes of research, public health, or health care operations; and
8. Disclosures which are incident to a use or disclosure otherwise permitted or authorized by law.

Signed: ______________________________ Date: __________________________

Print Name: ___________________________ Telephone: ______________________

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ____

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