Alliance Health

# Request for Accounting of Disclosures of Health Information

Consumer Name:_____ Date of Birth:_____
Medical Record #:_____
Enrollee Address:_____

_____

Number where you can be reached:_____

I hereby request an accounting of the disclosures of my health information from this agency's designated record set(s) that was made to persons/agencies outside of this agency from _____ to _____ (not to exceed a six (6) year period of time). I understand that the first accounting within a twelve (12) month period is free, but that I can be charged a reasonable fee for any additional accountings within the same time period. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension up to 30 days is needed. I further understand this accounting shall not include the following disclosures:

- To me/my personal representative/other persons involved in my care;
- To carry out treatment, payment, and health care operations;
- Disclosures requiring authorization
- Facility Directory;
- Disclosures for national security or intelligence purposes;
- To correctional institutions or law enforcement about a person in their custody;
- As part of a limited data set; or
- Disclosures that occurred prior to April 14, 2003.

_____ _____
Signature of consumer/legally responsible person Date

## This Section for Agency Use Only

**Date Request Received by Agency:**_____

☐ **Request APPROVED**
Agency Requirements:
☐ Provide consumer with copy of accounting within 60 days of request
☐ Ensure disclosures were made after 4-14-03

☐ **Compliance with Request DELAYED for no more than 30 days**
Reason for Delay:_____
Date accounting will be sent to consumer or personal representative: _____
Client/Personal Representative notified in writing of delay on: _____

☐ **Provision of Accounting of Disclosures to Oversight agencies or law enforcement suspended for:**
☐ 30 days (oral request) ☐ Specified Date/Event (written request) _____

☐ **Request WITHDRAWN by client or personal representative**

By: _____ _____ _____
Staff Title Date

Once completed, scan and save form to Patient-> Demographics->Consents.