



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**Request WITHDRAWN by client or personal representative**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