

Request for an Accounting of Disclosures Form

1. PATIENT INFORMATION

Date of Request: _____ Medical Record Number: _____

Name: _____ Date of Birth: _____

Telephone Number: _____

Address: _____

Address to send Accounting of Disclosure (if different than above):

2. DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. **Please note:** the maximum time frame that can be requested is six years prior to the date of your request.

From: _____ To: _____

3. FEES

There is no charge for the first request for accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is **\$25.00**.

4. RESPONSE TIME

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

Signature of patient/legal representative _____ Date _____

5. THIS SECTION FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: _____

Date acknowledgement notice sent: _____

Date accounting sent: _____

Requester verified by which method? _____

Extension requested: ☐ no ☐ yes If yes, give reason: _____

Staff member completing request: _____ Date: _____