REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Information

Patient Name: _____ Date of Birth: _____
Patient Address: _____
Date of Request: _____

Address to send disclosure accounting (if different from above): _____
_____
_____

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: _____

Fees

There is no charge for the first accounting request in a 12-month period. For subsequent requests in the same 12-month period, the charge is $_____. I understand that there is (check one):

_____ No fee for this request
_____ A fee for this request in the amount specified above and I wish to proceed.

Response Time

I understand 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: _____
Printed Name: _____ Date: _____
Legal Representative Relationship to patient: _____

For Administrative Use Only

Date request received: _____ Date accounting sent: _____
Extension requested: _____Yes _____No
If yes, give reason: _____
Patient notified in writing on this date: _____
Staff member processing request: _____

Distribution of copies: Original to Individual's record, copy to Individual