

Patient Label if Available **OR**

Print Patient Name

Patient Account #



Request for an Accounting of Disclosures

Date of Request: _____

Patient Name: _____

Date of Birth : _____ Medical Record Number: _____

Patient Address : _____

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

Dates Requested:

I would like an accounting of disclosures for the following time frame:
 (Please note: The earliest "from date" is April 14, 2003.)

From: ___/___/___ To: ___/___/___
 (no earlier than April 14, 2003)

Fees:

The first request in a 12-month period is free.
 There may be a charge for subsequent requests in that same 12-month period
 The fee for this request will be: _____

I understand that there may be a fee for this accounting, and I wish to proceed with my request. I also understand that the accounting 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 or Legal Representative _____
 Date

If Legal Representative, authority of Legal Representative _____
 (such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

For Healthcare Organization Use Only:

Date Received: _____ Date Accounting Sent: _____

Extension Requested: No ___ Yes ___ Reason: _____

Patient notified in writing on this date: _____

Staff Member Processing Request: _____

Place Patient Label Here **or**

Print Patient Name

Account Number



Disclosure Reporting Form

Instructions: This form is used to document patient disclosures that are subject to a patient's request for an "Accounting of Disclosures." Refer to Accounting of Disclosures Policy. Fill out the information below and send the form to Slot 524.

Name of the person making the disclosure: _____

Location: _____ Phone #: _____

* * * * *

Patient Name: _____

Last Name / First Name / MI

Date of birth: _____ Medical Record #: _____

Brief description of the information disclosed.

Date of the disclosure: _____ (MM/DD/YYYY)

Brief statement of the purpose of the disclosure.

Name of person or entity who received the information and address (if known).

Name of person filling out this form, if different than above:

EPF barcode....HIPAA