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REQUEST FOR ACCOUNTING OF DISCLOSURES

Please use this form to request that ____________ provide you with an accounting of certain disclosures of protected health information that have been made by _______________ during the specified time period.

Today's Date: _____/_____/_______

Patient Name:
Birthdate:
Address (address, city, state, zip code):
Phone:
E-Mail Address:
Time Period for Accounting (Please specify the dates between which you would like __________ to account for disclosures of protected health information.): Starting Date for Accounting __________________ Ending Date for Accounting ___________________
Requested Limitations on Scope of Accounting :
Signature of Patient or Personal Representative: ____________________________ Date: __________
Name of Personal Representative: _____________________ Relationship to Patient: _______________
(I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.)
Please return this form to: _________________________ _________________________ _________________________
FOR OFFICE USE ONLY: Date Released: ______________________ Released by: __________________