Request for an Accounting of Disclosures

Last Name: ____________________ First Name: ____________________ Middle Initial ________

Date of Birth: __________________ Social Security # ____________________________

Address to send disclosure accounting: ______________________________

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Dates Requested:
I would like an accounting of all disclosures for the following time frame: ___________________
(Please note that the maximum time frame that can be requested is seven years prior to the date of request, but not before 10/01/02)

Fees:
First request in a 12-month period: Free
Subsequent Requests: $___________
The fee for this request will be: $___________

I understand that there may be a fee for this accounting and wish to proceed. 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 Guardian Date

FOR HEALTHCARE ORGANIZATION USE ONLY:
Date Received: ____________________________ Date Sent: __________________________

Extension Requested: ☐ NO ☐ YES, Reason: ________________________________

Patient notified in writing on this date: ____

Copy of *Verification of Identity* of patient and / or legal representative obtained / filed: ☐

Staff member processing request: ____

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