



Request for an Accounting of Disclosures

Last Name: _____ First Name: _____ Middle Initial _____

Date of Birth: _____ Social Security # _____

Address to send disclosure accounting: _____

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: _____