[Insert Letterhead]

**Request for Accounting of Disclosures Form**

|  |  |
| --- | --- |
| Date: |  |
|  |  |
| Requestor’s Name |  |
| and Address: |  |
|  |  |
|  |  |
| Telephone Number: |  |
|  |  |
| Date of Birth: |  |
|  |  |
| Medical Record Number: |  |

Dates for Accounting of Disclosures (may not exceed 6 years from the date set forth above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limitations on Accounting Request (for example certain types of disclosures):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to an accounting of disclosures of my protected health information. Some exceptions include those for: (a) treatment, payment, or health care operations; (b) me or my personal representative; (c) notification of or to persons involved in my health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) a limited data set; (f) national security or intelligence purposes; or (g) correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody.

I understand that I am entitled to receive my first accounting in any 12-month period free of charge. If this is a subsequent request for accounting, then I also understand that [Insert Covered Entity name] may charge me a reasonable, cost-based fee for complying with the request. In the case of a subsequent request within any 12-month period, [Insert Covered Entity name] will notify me of the fee before processing my request for accounting and provide me with an opportunity to withdraw or modify my request for the subsequent accounting.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or personal representative signature (and relationship of personal representative)

For [Insert Covered Entity name] Use Only

Date Request for Accounting Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

First accounting requested within 12-month period: \_\_\_\_\_\_\_\_

Subsequent request: \_\_\_\_\_\_\_\_\_\_\_

Fee: \_\_\_\_\_\_\_\_\_\_

Notification of fee: \_\_\_\_\_\_\_\_\_

Fee accepted: \_\_\_\_\_\_\_\_\_\_

Request withdrawn: \_\_\_\_\_

Date Acknowledgment Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deadline to Respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deadline Extended: \_\_\_\_\_\_ No

\_\_\_\_\_\_Yes Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date written notification given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New deadline to respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Accounting Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Officer/Designee Date