

## REQUEST FOR AN ACCOUNTING OF DISCLOSURES (Please Print)

PATIENT INFORMATION				
Patient's last name:	First:	Middle Initial:	Birth date:	Sex : <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security or Record #:	
City:	State:	ZIP Code:	Home phone:	Cell phone:

PERSON/ORGANIZATION ACCOUNTING FOR DISCLOSURES		
Name of Practitioner/Clinic:		
Address:		
City:	State:	Zip Code:

TIME PERIOD FOR ACCOUNTING AND/OR TYPE OF RECORDS	
<i>I would like an accounting for disclosures for the following time periods (no earlier than April 14, 2003)</i>	
FROM:	TO:
<i>If you want an accounting only for a certain type of information or for disclosures only to a particular person or organization, please describe the accounting for disclosures that you want:</i>	

WHEN THE ACCOUNTING WILL BE DELIVERED
I understand that the accounting will be provided to me within 60 days of the date of this request, unless a 30 day extension is requested by the practitioner/clinic within 60 days of the date of this request. The practitioner/clinic will provide a written explanation for the reason(s) for the delay and the date by which I can expect to receive the accounting.

LIMITS ON ACCOUNTING
I understand that you are not required to account for some disclosures you make such as:
- For treatment, payment and health care operations    - Directly to me as patient    - To family and friends who are part of or pay for my care
- For disaster relief purposes    - For national security purposes    - To law enforcement personnel    - As part of a limited data set

<b>Patient/Authorized signature:</b>	<b>Date:</b>
<i>If signed by person other than patient print Name of Authorized Person and relation to patient and authority to authorize:</i>	

FOR OFFICE USE ONLY	
Date Received:	Date Sent to Requester:
Name and Title of Person who fulfilled this Request:	
Signature of Person who fulfilled this Request:	