Request For Accounting of Disclosures of Health Information

Name: ____________________________ Social Security Number: ___________________________

Primary Physician: __________________ Date of Request:__________________________________

I hereby request an accounting of disclosures of my protected heath information. I understand that the disclosures you will report will be disclosures to others for purposes other than payment, treatment or healthcare operations and in accordance with the HIPAA Privacy Rule (Section 164.528).

Beginning Date:____________________ Ending Date: _____________________________________

Please provide an accounting of all disclosures made during the above referenced date range and in regard to the following:

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Signature of the Patient: ___________________________

Signature of Guarantor: ___________________________
(Sign If Patient Is A Minor)

(Office Use Only)

Date received by Site Compliance Contact/Office Manager: __________________

Date Accounting of Disclosures Released: ____________

Prepared by: ____________________________________

Sent by: Mail Courier UPS Certified

Patient Picked Up: ________________________________
(Signature of Patient)