Request for Accounting of Disclosures of Health Information

Please print all requested information to prevent delays in our response & provide completed form to your facility.

Patient Name: _____
Last First MI Maiden or Other Name

Address: _____ City:_____ ST:_____ Zip:_____

Date of Birth:_____-_____-_____ **Phone #:_____**

I request an accounting for disclosures of my health information for the period: **From:_____To:____**

I understand that this accounting for disclosures will include disclosures made only to those organizations or persons *other than:*

- **to those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out your operations;**
- to myself or persons involved in my care;
- pursuant to my authorization;
- for national security or intelligence purposes;
- to correctional institutions or law enforcement officials under certain circumstance; or
- those occurring prior to April 14, 2003
- those exceeding a period of six years prior to the date of this request.

I understand that my request for an accounting of disclosures will be processed within 60 days of submitting this form. I will be notified of the need for an extension of not more than 30 days to process the request, the reasons for the delay and the date when I can expect to receive the requested accounting.

Please send this accounting by:
❑ Paper Copy ❑ Call at number above to pick up OR ❑ Mail to address above

*❑ Email_____ OR ❑ Other electronic method _____

***For security of your records, all emails are routinely sent encrypted.**

Unencrypted email disclaimer:
❑ I understand that records sent through unencrypted email poses a security risk and that is my requested method of receipt._____(Please initial)

_____ _____
SIGNATURE OF PATIENT **DATE**

OR

_____ _____
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON **DATE**

_____ _____
RELATIONSHIP TO PATIENT **DATE**

Partners in Integrated Care. Cardiology | CAC FLORIDA Medical Centers | Continucare Medical Centers | MetCare | Partners in Primary Care.

REQUEST for ACCOUNTING OF DISCLOSURES of HEALTH INFORMATION

Please print all requested information to prevent delays in our response & provide completed form to your facility.

FOR INTERNAL USE ONLY

Complete the sections below and place in patient record.

Notice of Decision

Disclosure Handling: ❑ Completed ❑ Denied

If denied, reason for denial is:

- ❑ Disclosures occurred prior to April 14, 2003
- ❑ Disclosure exceeds more than a six-year period
- ❑ No disclosures made for reasons other than those permitted as listed above.

_____ _____

Name of associate that processed request | Date Request was processed