Request for an Accounting of Disclosures

Patient Name: _____

Patient Date of Birth: _____

Patient's Address: _____
_____
_____

Please specify the time period for which you are requesting the accounting of disclosure:
From Date: _____To Date: _____

This is the first request for an accounting of disclosure □ yes □ no

(***The first request in a 12-month period is free of charge. There is a processing fee for more than one request in a 12-month period***)

Printed Name of Individual Completing this Request: _____

Relationship to Patient Named Above: _____

Address of Individual Completing this Request (if other than patient)
_____
_____
_____

Signature of Patient or Legal Representative_____

(If someone other than the patient is requesting the accounting of disclosure – must be a legal representative as defined in SBUMC Admin. Policy # IM: 0065 Access to PHI by a Personal Representative – parent of an unemancipated minor, legal guardian, appointed healthcare proxy or agent)

This section for SBUMC Use Only

Date Request Received: _____
Accounting has been: □ granted - Copy provided to requester on _____ (date)
□ not granted - Letter written to requester on _____ (date)

Printed Name and Title of SBUMC Staff Member Processing Request:
_____

Signature of Privacy Officer or Designee _____ Date _____