Name of Client/Patient Date of Birth (mm/dd/yyyy) Phone Number

Address City, State, Zip

Client/Patient has the right to an accounting of the disclosures we make of your Protected Health Information (PHI). We are only required to provide an accounting for the seven (7) years prior to the request. We do not have to account for disclosures we make for the following reasons:

(a) for treatment, payment, or health care operations activities,

(b) directly to the client/patient or the client’s/patient’s personal representative;

(c) as part of a limited data set for research, public health or Health Care operations activities,

(d) for national security or intelligence purposes, or to law enforcement or correctional institutions regarding persons in lawful custody,

(e) incidental to a permitted or required use or disclosure**;**

(f) to persons involved in the client’s/patient’s care; or

(g) any other purpose authorized under HIPAA.

Please specify the accounting period you are requesting: From:       /       /       To:      /       /

Client/Patient is entitled to one free disclosure accounting every 12 months. By law we are allowed to charge a reasonable fee for each additional disclosure accounting requested during the same 12-month period.

Signature: Date:

If this form is completed by a parent/guardian/authorized agent on behalf of the client/patient, complete the following:

Parent/Guardian/Authorized Agent’s Name (please print)

Please check one of the following:

Parent/Guardian

Authorized Agent

|  |
| --- |
| For Office Use Only If Records Requested to be Inspected:  Name of Inspecting Person:  Records Released for Inspection: |

***We will respond to this request within 60 days of receipt of your request, unless we need a 30-day extension. If we need an extension, we will let you know within the 60-day response period.***