Patient Request for Accounting of Disclosure

PLEASE READ THE FOLLOWING:

You have the right to an accounting of certain disclosures we or our business associates have made of your protected health information (PHI) within 60 days after Advocate Health's receipt of the request. An Accounting of Disclosure does not include a list of people who have reviewed your electronic Health records. Accountable disclosures include all disclosures of PHI, with the following exceptions of disclosures that were:

a) For Treatment, Payment, or Health Care Operations purposes.
b) Made to the individual to which the PHI pertains.
c) Incident to a use or disclosure otherwise permitted or required by HIPAA.
d) Made pursuant to an authorization.
e) Made via the patient directory or to family and friends for care and notification purposes.
f) Made to correctional institutions or law enforcement officials (of individuals in lawful custody)
g) Part of a Limited Data Set (all patient identifying data elements such as names, address, telephone numbers, account numbers have been excluded).

Section 1: PATIENT INFORMATION

_____ _____ (_____) _____

Full Legal Name of Patient | Date of Birth | Telephone Number

_____ _____

Address | City/State/Zip

Section 2: DATES REQUESTED

I would like an accounting of all disclosures for the following time frame (add the month/year below).

Please note: the maximum time frame that can be requested is six (6) years prior to the date of your request.

From:_____To: _____

Section 3: FEES

There is no charge for the first accounting request in a 12-month period. For subsequent requests in the same 12-month period, a fee of
$20 for each subsequent accounting in the same 12-month period. Check one of the boxes below.

☐ I agree with the fee above and wish to proceed with this request. ☐ Fee is not applicable, 1st accounting

Section 4: DELIVERY MECHANISM SIGNATURE OF AUTHORIZED INDIVIDUAL

Preferred Contact Method for Accounting of Disclosure Communications

☐ **Patient Portal** ☐ **Mail to address above** ☐ **Encrypted**

Email Address: _____

_____

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE **DATE**

If signed by a person other than the patient, state your relationship to the patient: _____

Please return form to: medicalrecordsroi@advocatehealth.org

Atrium Health

Place Patient Label Here