

You have the right to request an accounting of uses and disclosures of your personal health information. This accounting does not include uses and disclosures related to treatment, healthcare operations, disclosures for which you may have already provided written authorization, national security intelligence or uses and disclosures made to correctional institutes or law enforcement officials. One accounting per year shall be provided at no charge. Additional requests for accounting's in the same calendar year shall be subject to additional fees.

Patient Name:	Social Security/MRN:
Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:

*Please specify the dates for which you would like an accounting: **Please note: All requests must be for disclosures after April 14, 2003 and cannot be for a period of more than six (6) years prior to the date of your request for an accounting.***

Accounting between the dates of \_\_\_\_\_ and \_\_\_\_\_

Format of your accounting

Paper                       Electronic: Provide EMAIL address: \_\_\_\_\_

Please specify method of release:

Pick-up                       Certified Mail to:

**\* Please note: A fee will be charged for the cost of mailing paper records**

Name:	Title/Business:
Street Address:	City, State, Zip Code:
Phone Number:	Relationship to Patient:

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If other than patient, cite authority and attach proof if applicable: \_\_\_\_\_)

*Internal use only:*

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_