PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Please forward this form to the Medical Record Department of the Providence Healthcare facility at which you were seen. If you were seen at multiple facilities or are unsure of the appropriate contact information, you may forward the request to:

PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name:		DOB:	
Address:		Phone:	

I request that Providence Health & Services (PH&S) provide me with an accounting of the disclosures of my protected health information made by PH&S for the following time period:

From: ____________ To: ____________

I understand that PH&S is not required to tell me about the following types of disclosures:

- Disclosures for purposes of treatment, payment and health care operations or as part of a limited data set
- Disclosures to me or authorized by me
- Disclosures for use in the hospital's directory
- Disclosures to persons involved in my care
- Disclosures for notification purposes (to notify family members/personal representatives of my location, general condition or death).
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- Disclosures made more than six years prior to the date of the request
- Disclosures otherwise permitted or required by federal or state law.

I understand that my right to an accounting of some or all disclosures may be suspended by law enforcement or government officials under limited circumstances.

I also understand that I am entitled to an accounting free of charge every 12 months, and that I may be charged if I request any additional accountings within the same 12 months. I understand that I will be notified of the cost involved and will have the opportunity at that time to withdraw or modify my request before any costs are incurred.

Please provide me with the accounting (select one): ☐ Paper ☐ CD ☐ Email

Sign Here: ______________________________ Date: ____________

Personal Representative's Name: ______________________________

Relationship to Patient: ☐ Power of Attorney for Healthcare* ☐ Legal Guardian*
☐ Parent ☐ Other

*Attach legal documentation if you are the legal guardian or Power of Attorney for Health care

If you believe your privacy rights have been violated, you may file a complaint with this facility or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

For Internal Use Only
Date Received:___________ Initials _______________ MRN_________________________
Date Entered into Accounting of Disclosures Database: __________