

# Patient Request for Accounting of Disclosures of PHI



Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## ***Right to Request an Accounting of Disclosures of PHI and Our Duties:***

You (or your authorized representative) have the right to receive an accounting of certain disclosures of your PHI made within six (6) years immediately preceding your request. But, we are not required to provide you with an accounting of disclosures of your PHI: (a) for purposes of treatment, payment, or healthcare operations; (b) for disclosures that you expressly authorized; (c) disclosures made to you, your family or friends, or (d) disclosures made for law enforcement or certain other governmental purposes.

## ***Request for an Accounting of Disclosures of PHI:***

Below, please specify the period of time for which you are requesting an accounting of disclosures of your PHI. If you do not specify a time period, Taney County Ambulance District will provide an accounting of disclosures during the previous six (6) years that we were required to track.

*Period of time for which I am requesting an accounting:* \_\_\_\_\_

***Signature of Requestor:*** \_\_\_\_\_ ***Request Date:*** \_\_\_\_\_

## ***Requestor Information (if requestor is different from patient):***

Name: \_\_\_\_\_

Relationship to Patient (parent, legal guardian, etc.): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_