**Request for Accounting of Disclosures of Protected Health Information**

***As required by the Health Insurance*** ***Portability and Accountability Act of 1996 (HIPAA), you have a right to request an accounting of disclosures of health information that pertains to you. Exceptions to Accounting of Disclosures are:***

* Disclosures made for treatment, payment, or healthcare operations;
* Disclosures made to individuals of protected health information about themselves;
* Disclosures made pursuant to a valid authorization;
* Disclosures made for the hospital’s directory or to person(s) involved in the individual’s care;
* Disclosures made for national security or intelligence purposes;
* Disclosures made to correctional institutions or law enforcement officials;
* Disclosures made as part of a limited data set; or
* Disclosures made that occurred prior to the compliance date.

“Disclosure” means the release of the information to a party outside of the covered entity holding the information.

Disclosure does **not** include uses or accesses of information made within the covered entity by members of the covered entity’s workforce.

**REQUEST SECTION:**

I, (print name), hereby request an accounting of disclosures of my protected health information that have occurred .
(*Specify time frame; not to exceed 6 years, nor to predate April 14, 2003*)

Patient Name: Date of Birth:

 *(First, Middle, Maiden, Last) (Month/Day/Year)*

Patient Address:

 *(Street Number, City, State, Zip Code)*

Signed: Date:

Print Name: Telephone:

If not signed by the patient, please indicate relationship:

* Parent or guardian of minor patient;
* Guardian or conservator of an incompetent patient;
* Beneficiary or personal representative of deceased patient;
* Other (specify)

*Copy of any documentation confirming the above relationship must accompany form.*