REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Information

Name of Patient: _____

Date of Birth: _____ Account # _____

Date of this Request: _____

Address: _____

Address to which accounting shall be sent if different than above: _____

Request for Accounting of Disclosures and Dates Requested

I understand that I have the right to receive an accounting (or list) of certain disclosures of my protected health information made by the Muslim Community Center Medical Center during the six (6) years prior to the date of this request. I hereby request an accounting of the disclosures of my protected health information that were made during the following time frame:

From: _____ [mo/date/year] To: _____ [mo/date/year]

Fees

I understand that I am entitled to my first accounting in any twelve (12) month period free of charge. I also understand that the Muslim Community Center Medical Center may impose a reasonable cost-based fee for each of my subsequent requests within the same twelve (12) month period, and that I will have the opportunity to withdraw or modify my request for a subsequent accounting in order to avoid or reduce this fee. I understand that, with respect to this request, there is [check one]:

☐ No fee for this request

☐ A fee for this request in the amount of $_____ [insert cost-based fee], and I wish to proceed.

Response Time

I understand that the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 day is needed.

_____ _____

Signature of Patient Date

RESET PRINT

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