

# REQUEST FOR ACCOUNTING OF DISCLOSURES



Release of Information - SCAN, REQ ACCT OF DISCLOSURES, 8/21/24

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

**Important Information:** As provided for under the Health Insurance Portability and Accountability Act (HIPAA) and federal regulations patients have the right to request an Accounting of Disclosures of certain disclosures of their health information that were made to persons, entities or organizations outside of Catholic Health. Please see the Notice of Privacy Practices, available at <https://www.chsli.org/for-patients-visitors/patient-privacyhipaa-rights> for a more detailed description of your rights to request this accounting and the related process.

You are entitled to a free accounting of disclosures report every twelve months. If you have already requested an Accounting of Disclosures within the last twelve months, you may be charged a reasonable fee to cover the costs of producing any additional requests. You will be notified before any fees are charged so that you may decide whether to continue with your request, modify your request or withdraw your request and pay no fee.

**Request Details:**

I hereby request an accounting of disclosures made during the following period of time:

FROM: \_\_\_\_/\_\_\_\_/\_\_\_\_ TO: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy mm dd yyyy

Catholic Health Facility/Entity treated at: \_\_\_\_\_

Patient or Personal Representative Name:

\_\_\_\_\_  
Print\_\_\_\_\_  
Signature

If Personal Representative, please complete the information below:

\_\_\_\_\_  
Relationship to Patient\_\_\_\_\_  
Contact Information (if different from above)**FOR CATHOLIC HEALTH USE ONLY**

Date Request Received: \_\_\_\_\_ Facility/Entity: \_\_\_\_\_

Name of Workforce Member Processing: \_\_\_\_\_

MRN: \_\_\_\_\_ CSN: \_\_\_\_\_

Request Fulfilled: \_\_\_\_\_ Request Sent: \_\_\_\_\_