

[NAME OF PRACTICE]

**REQUEST FOR ACCOUNTING OF DISCLOSURES OF  
PROTECTED HEALTH INFORMATION**

You have a right to request that [Name of Practice] ("Covered Entity") provide you with an accounting of certain disclosures that it has made of your protected health information. Please see Covered Entity's Notice of Privacy Practices or contact Covered Entity's privacy official at [Telephone Number of Practice] for information.

Please submit this form to: [Name of Privacy Official], Privacy Official  
[Name of Practice]  
[Address of Practice]

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Daytime telephone number** \_\_\_\_\_

**Please select one:**

\_\_\_\_\_ I am a patient of Covered Entity.

\_\_\_\_\_ I am the personal representative of a patient of Covered Entity (*please attach proof of personal representative status*).

**I would like an accounting of covered disclosures of my protected health information made by Covered Entity between the following dates:**

\_\_\_\_\_ and \_\_\_\_\_.

**Note:** We are not required to provide an accounting for disclosures we made more than six (6) years prior to the date of the request.

**Please Read Carefully and Sign**

I understand that Covered Entity will provide the requested accounting of disclosures if required to do so under applicable law. If this is not my first request for an accounting within a 12-month period, I understand that Covered Entity will notify me of its reasonable costs for complying with my request and provide me with the opportunity to agree to pay those charges in order to receive the requested accounting.

\_\_\_\_\_  
By:

\_\_\_\_\_  
Date

**Please note:** Applicable law requires us to respond to you within 60 days after receiving your request, unless we send you a notification that we will need an additional 30 days to respond.