*(For use by clients or participants requesting an accounting of disclosures.)*

***Include any special instructions determined by the organization itself or state law.***

|  |  |
| --- | --- |
| Name: | ID Number: |
| Record Holder: | Date of Birth: |
| Location of Record: | Date of Request: |

You can ask for a list of disclosures of your Protected Health Information made by the organization. If you would like this information, please consider the following:

* The list is free one time in any twelve-month period. The organization may charge you for additional lists in the same twelve-month period.
* The organization will not list disclosures made more than six years before your request.
* The organization will not list disclosures made earlier than (enter date here).
* The organization will only list disclosures of Protected Health Information not related to Treatment, Payment, or Health Care Operations.
* The organization will not list disclosures that you authorized.

I am asking for a list of disclosures for the following period of time: (be specific)

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(See other side for information on client or participant rights)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Approved | |  | | |  | |
| Denied | |  | | |  | |
| Delayed | |  | | |  | |
|  | | | | | | |
| If Delayed, we will act on your request by | | | | | |  |
| Comments: | | |  | | | |
|  |  | | |  | | | |
|  |  | | | | | |
|  | Organization Representative Signature Date | | | | | |

**Your Rights to an Accounting of Disclosures:**

* You have a right to request an accounting of disclosures made by the organization of your information.
* You have a right to have an answer to your request within 60 days. If there are delays in getting you the answer, you will be told. The delay cannot be more than 30 days. You’ll receive an answer in writing.
* Your first request for an accounting in a twelve-month period is free. You may be charged for additional requests in the same twelve-month period.

*You have a right to file a privacy complaint:*

Individuals can file privacy complaints with either the organization or with the U.S. Department of Health and Human Services, Office for Civil Rights.

Privacy complaints may be directed to any of the following:

## Organization Name

### Name of person to be contacted within organization

Organization Address

### Phone Number

Fax Number

Email Address

## U.S. Department of Health and Human Services, Office for Civil Rights

Medical Privacy, Complaint Division

200 Independence Avenue, SW

# HHH Building, Room 509H

Washington, D.C. 20201

### Phone: 866-627-7748

TTY: 886-788-4989 Email: www.hhs.gov/ocr