REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Information:

Name: ____Date of Birth:________________________________

Social Security Number: ______________________________Medical Record Number: ______________________

Account Number(s):____

Address: ____

Address To Send Disclosure Accounting (If Different From Above):

____

Dates Requested:

I would like an accounting of disclosures for the dates noted below:

From: ____________________________ To: _______________________

(Note: The earliest date of disclosure information that can be provided is April 14, 2003, in accordance with the HIPAA Privacy Regulation 45 CFR 164.528)

Fees:
There is no charge for the first accounting request. For subsequent requests within the 12 month period, the charge is $______.
I understand that there is: (check one)

☐ No fee for this request **OR**

☐ A fee for this request in the amount specified above and I wish to proceed

Response Time:
I understand 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 days is needed.

____ ____________________________

Signature of Patient or Legal Representative Date

THIS SECTION TO BE COMPLETED BY CAPE FEAR VALLEY HEALTH SYSTEM STAFF:

Date request received: _____________________________ Date accounting mailed: _______________________

Extension requested: ☐ Yes ☐ No

If yes state reason for extension:____.

Patient or legal representative notified of need for extension. Copy of notice mailed on _______________.
(Date)

Staff Signature:____ Facility Name: _________________________