Request for Accounting of Disclosures of Protected Health Information

Patient Information

Last Name	*First*	*Middle*		*Request Made on: (mm/dd/yyyy)*
Street Address	*City*	*State*	*Zip*	*Birth Date: (mm/dd/yyyy)*
Patient's Personal Representative Name				*Patient's Phone #*

Request for Accounting of Disclosures

I hereby request an accounting of disclosures of my health information as follows (CHECK ONE):

☐ For all disclosures, subject to HIPAA accounting requirements made during the six (6) year period prior to the date of this request

☐ For all disclosures, subject to HIPAA accounting requirements made during the following time period:
From: ☐ To: ☐

I understand that the first accounting in any twelve (12) month period, will be provided to me at no cost. For any additional accounting requests made within the same twelve (12) month period, Lamoille Health Partners may charge a reasonable fee.

Date: _____

Signature of Patient/Representative: _____

Printed Patient/Representative Name: _____

For Lamoille Health Partners Internal Use Only

Date request received: ☐

☐ Date accounting report due: _____/_____/_____

☐ Accounting completed: _____/_____/_____

☐ Written request for 30-day extension sent: _____/_____/_____

☐ Date final accounting report sent: _____/_____/_____

Signature of Lamoille Health Partners Privacy & Security Officer: _____Date: ____/____/____

Origin 07/26/2016
Form 500.332G