

KEWAUNEE COUNTY**REQUEST FOR AN ACCOUNTING OF DISCLOSURES****PATIENT INFORMATION**

Date of Request: _____ **Medical Record No.:** _____

Name: _____ Date of Birth: _____

Address: _____

Address to send disclosure accounting (if different from above):

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note: the maximum time frame that can be requested is six years prior to the date of your request.*

From: _____ To: _____

FEES

There is no charge for the first accounting request in a 12-month period. For subsequent requests in the same 12-month period, the charge is \$_____. I understand that there is (check one):

_____ No fee for this request

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

If this fee is unacceptable to me I do not need to complete this form, but I understand that if I don't complete this form I will not receive my requested accounting of disclosures.

RESPONSE TIME

1. The organization must take action within 30 days after receipt of the request when the PHI is on-site, and within 60 days when the PHI is off-site. One 30-day extension is permitted, if the organization provides the patient with a written statement of the reasons for the delay and the date by which the access request will be processed.

Signature of Patient or Legal Representative

Date

FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: _____ Date accounting sent: _____

Extension requested: _____ Yes _____ No

If yes, give reason:

Patient notified in writing on this date: _____

Staff member processing request: _____

