Accounting for Disclosure Request Form

PATIENT INFORMATION

Patient Name _____ Date of Request _____

Address _____ Date of Birth _____

City, State, Zip Code _____ Telephone _____

Address to send Accounting of Disclosure (if different than above):

_____

LOCATION/DATES REQUESTED

I would like an accounting of all disclosures for the following Aspirus location and time frame. *Please note:* the maximum time frame that can be requested is six years prior to the date of your request, and the health care entity is not required to account for disclosures that occurred before April 14, 2003.

Aspirus Location: _____

From: _____ To: _____

FEES

There is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is $15. I understand that there is (check one):

☐ No fee for this request.

☐ A fee for this request in the amount of $15, and I wish to proceed.

RESPONSE TIME

I understand that the accounting I have requested will be provided, by mail, to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent/Legal Representative Relationship Date

THIS SECTION FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: _____ Date accounting sent: _____

Patient MRN: _____ Staff member processing request: _____

Requestor verified by which method? _____

Extension requested: ☐ No ☐ Yes If yes, give reason: _____

Patient notified in writing on this date: _____