

**BEHAVIORAL HEALTH AND HEALTH FACILITIES
REQUEST FOR ACCOUNTING OF DISCLOSURES**

Date of Request: _____/_____/_____

Patient Name: _____

Patient Address: _____
Street Address

City/State/Zip

Date of Birth: _____/_____/_____ SS# _____/_____/_____

I would like an accounting of all disclosures for the following time frame.
(Note: The maximum time frame that can be requested is six years prior to the date of this request and not prior to April 14, 2003).

From: _____ To: _____

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

Fees:

First request in a 12-month period: Free Subsequent Requests: [ENTITY FEE]

The fee for this request will be: Free \$ _____

I understand that there is a fee for this accounting and wish to proceed. I also understand that the accounting 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

For Healthcare Organization Use Only:

Date Received: _____/_____/_____ Date Sent: _____/_____/_____

Extension Requested: Yes No Reason: _____

If yes, patient notified on: _____/_____/_____

Staff member processing request: _____