Catholic Health

REQUEST FOR ACCOUNTING OF DISCLOSURES

Release of Information - SCAN, REQ ACCT OF DISCLOSURES, 8/30/23

Patient Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Important Information: *As provided for under he Health Insurance Portability and Accountability Act (HIPAA) and federal regulations patients have the right to request an Accounting of Disclosures of certain disclosures of their health information that were made to persons, entities or organizations outside of Catholic Health. Please see the Notice of Privacy Practices, available a https://www.chsli.org/for-patients-visitors/patient-privacyhipaa-rights for a more detailed description of your rights to request this accounting and the related process.*

You are entitled to a free accounting of disclosures report every twelve months. If you have already requested an Accounting of Disclosures within the last twelve months, you may be charged a reasonable fee to cover the costs of producing an additional requests. You will be notified before any fees are charged so that you may decide whether to continue with your request, modify your request or withdraw your request and pay no fee.

Request Details:

I hereby request an accounting of disclosures made during the following period of time:

FROM: _____/_____/_____ TO: _____/_____/_____
mm dd yyyy mm dd yyyy

Catholic Health Facility/Entity treated at: _____

Patient or Personal Representative Name:

_____ _____
Print Signature

If Personal Representative, please complete the information below:

_____ _____
Relationship to Patient Contact Information (if different from above)

FOR CATHOLIC HEALTH USE ONLY

Date Request Received: _____ Facility/Entity: _____

Name of Workforce Member Processing: _____

MRN: _____ CSN: _____

Request Fulfilled: _____ Request Sent: _____