GOLD COAST
MEDICAL

Request for an Accounting of Disclosures Form

The purpose of this form is to request an accounting of disclosures of protected health information made by our organization.

Date of Request: ______________________

Information on Person Requesting Accounting

Patient Name:___________________________________Date of Birth: ________________

Patient Address: ____

____

Medical Record/Set: ____

Timeframe of Request

I would like to request a complete accounting of all disclosures made during the following time frame:

From Date:_________________To Date: _________________

[Note: The maximum time frame of request cannot exceed six years prior to request date above.]

Fees for Request

The first request in a 12 month period will be provided free of charge. For all subsequent requests the fee will be:_______with the cost of this request being:_______________.

Acknowledgment of Request

I hereby acknowledge the above request and understand that I will be responsible for the payment of the above fee (if any) in connection with this request.

____ _________________

Signature of Patient or Legal Patient Representative *Date*

[Note: All requests will be provided to me within 60 days, unless an extension is required in which case I will be notified in writing. In any case, my request will not take longer than 90 days to fulfill.]

**************** [Do Not Write in Section Below – For Healthcare Provider Use Only] ****************

Assigned To:_____Date Delivered to Patient:_

Extension Requested: [ ] Patient Notified: [ ] Date Notified:________________

Reason: ____