

ACCOUNTING of DISCLOSURES

Patient's Right to Request an Accounting of Disclosures

There are limitations on our obligation to provide an accounting of disclosures of your health information, which we state in our Notice of Privacy Practices. We would be glad to discuss these limitations with you before you complete this form.

Please complete this form to request an accounting of disclosures of your health information.

I, _____ request that Chippewa County Health Department provide me with an accounting of disclosures of: ___ my health information, or ___ the health information of _____ for whom I am the personal representative.
(patient name)

I request the accounting for the period _____ to _____

Please note, we cannot provide an accounting for disclosures made before April 14, 2003.

I understand that Chippewa County Health Department may charge an hourly fee of \$12.00 for this service, with a minimum charge of one (1) hour.

Signature of requestor: _____ Date of request: _____

If the requestor is the patient's personal representative, relationship to patient: _____