FERRIS STATE UNIVERSITY
College of Health Professions

REQUEST FOR ACCOUNTING OF DISCLOSURE

This form documents a patient's request for an accounting of disclosures of the patient's protected health information.

Notice to Patients: Please use this form to make a request that our practice provide you with an accounting of disclosures of your protected health information.

Patient Name: _____

Patient DOB: _____(For identification purposes)

Disclosure Accounting Request

Time Frame

Please specify the dates between which you would like for our practice to account for disclosures of your protected health information. Under HIPAA, we are not required to include certain disclosures, including disclosures for treatment, payment or healthcare operations.

Starting Date for Disclosure: _____

Ending Date for Disclosure: _____

Our Practice's Contact Person

Please contact the DH Clinic Operations Supervisor, our Practice's Privacy Officer if you have any questions relating to your Accounting of Disclosure request.

Patient Information

Print Name:

_____

Signature:

_____

Date: _____