PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name:

Patient Address:

Medical Record #: Date Of Birth: MM DD YY

Name and Address of Requestor if not patient:

Please consider this a request for an accounting of all disclosures for the time frames indicated below. (The maximum time frame that can be requested is six years prior to the date of the request, but not before April 14, 2003). I understand that there is a fee for this accounting and wish to proceed. I understand that the accounting will be provided to me within sixty days unless I am notified in writing an extension of up to thirty days is necessary.

Patient or Requestor to complete:			**Practice to complete:**		
From Date(s):	To Date(s):	Purpose of Disclosure	Date Request Received	Date Information Provided to Patient	Fee

Date:	Signature of Patient or Legal Representative:
Date:	Signature of Patient or Legal Representative:
Date:	Signature of Patient or Legal Representative:

RETAIN IN PATIENT RECORD

FOR SECURITY PURPOSES THIS DOCUMENT HAS A COLORED BACKGROUND TO PREVENT UNAUTHORIZED DUPLICATION.

Form 106

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SAMPLE