COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY®

Request for Accounting of Disclosures of Protected Health Information

Patient Information

Patient Name:	Request Made on: ___/_____/_____ Date
Street Address:	Birth Date:
City/State/Zip:	Telephone #:
Patient's Personal Representative Name:	

Request for Accounting of Disclosures

I hereby request an accounting of disclosures of my health information as follows (CHECK ONE):

❑ For all disclosures, subject to HIPAA accounting requirements made during the six (6) year period prior to the date of this request

❑ For all disclosures, subject to HIPAA accounting requirements made during the following time period: From: _________________ To: __________________

I understand that the first accounting in any twelve (12) month period, will be provided to me at no cost. For any additional accounting requests made within the same twelve (12) month period, CHSLV may charge a reasonable fee.

Date: ____________________________________

Signature of Patient/Representative :____________________________________

Printed Patient/Representative Name: ___________________________________

FOR CHSLV INTERNAL USE ONLY

Date Request received: _____/______/_______	❑ Date Accounting Report Due: ___/_____/_____ ❑ Accounting Completed: ___/_____/_____ ❑ Written request for 30- day extension Sent: ___/_____/_____ ❑ Date Final Accounting Report Sent: ___/_____/_____

____ _____/______/_______
Signature of CHSLV Privacy & Security Officer Date