REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name:____

Date of Birth: ______________________________Medical Record Number: __________

Address: ____

Phone Number:____________________

I am requesting a list of when, to whom and why The MetroHealth System (MHS) disclosed my protected health information. I understand that I will not be charged for the first request. If I make a second request within 12 months I will be charged a reasonable cost-based fee. I understand that MHS will send the list within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

I am requesting a list from the date of____ to the date of_____________________________(maximum time frame is six years from date of request).

I understand that MHS does not have to provide me with information that was disclosed:

1. To carry out treatment, payment and healthcare operations
2. To me or with my authorization
3. For the facility directory
4. For national security or intelligence purposes
5. To correctional institutions or law enforcement officials
6. As part of a limited data set
7. As otherwise excluded by law

Patient Signature:____Date:_____________

Name of Personal Representative (if applicable): ____

Signature of Personal Representative:______________________________Date:_____________

Relationship to Patient: ____

Send completed form to HIPAAprivacy@metrohealth.org, fax to (216) 778-8777, or mail to The MetroHealth System, Attn: Privacy, 2500 Metrohealth Drive, Cleveland, OH 44109

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For MHS use only:

Date Request Received: ________________ Date Request Fulfilled: _______________________

Extension Required? Yes ☐ No ☐ If yes, provide reason for extension: ______________________

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Name and Title of Reviewers: ____

Final Action Taken: ____

Privacy Officer's/Designee's Signature:______________________________Date: __________