MetroHealth

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: _____

_____

Name and Title of Reviewers: _____

Final Action Taken: _____

Privacy Officer's/Designee's Signature:_____Date: _____