SILVER STATE NEUROLOGY

Request for Accounting of Disclosures of PHI (Protected Health Information)

Patient Name: _____ **Patient ID #:** _____

I hereby request SILVER STATE NEUROLOGY to provide me with an accounting of disclosures made of my protected health information during the following period:

Period Requested: _____

Note: Period requested cannot be more than six years prior to the date on which this accounting is requested

And mail them to me at the following address:

Address1: _____ **Home Phone:** _____

Address2: _____ **Work Phone:** _____

City/State/Zip: _____

I understand that this accounting will not reflect disclosures:

1. That are made to carry out treatment, payment and health care operations
2. Made to me or my personal representative
3. Made to persons involved in my care or for purposes of notifying or identifying persons involved in my care
4. For national security or intelligence purposes
5. To correctional institutions or law enforcement officials
6. Made prior to April 14, 2003
7. Made pursuant to an authorization
8. That are incidental to other permissible uses or disclosures
9. That are part of a limited data set (does not contain protected health information that directly identifies individuals)

And I understand that there may be a fee associated with the request which is:

Fee: _____

Fee Schedule:

First request in a 12 month period	Free
Subsequent requests	

And I understand that:

Within 60 days, I will receive a response from SILVER STATE NEUROLOGY, or a notification that they require an additional 30 days to process my request. If they require an extension, they will explain the reason for the delay and the date by which they will complete my request.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Temporarily Suspended (*if applicable*): FOR OFFICE USE ONLY

☐ Under 45 CFR §164.528(a)(2), disclosure is temporarily suspended by a (*Check One*) _____health oversight agency or _____law enforcement

Agency Name _____ **Agency Phone** _____

Agency Contact Name _____ **Suspended Until Date** _____

Date Request Received _____ **Received By** _____

Date Request Fulfilled _____ **Fulfilled By** _____

Extension Requested ____Yes ____No **Date Patient Notified in Writing of Extension** _____

If Extension Requested, Give Reason _____