Mercy

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

Name of Individual: _____

Mailing Address: _____

City, State & Zip: _____

Date of birth: _____ Telephone: _____ Social Security #: _____

Dates of Request: ***From:*** _____ ***To:*** _____ *(Not to exceed six years from the date of the request.)*

Mercy location the Accounting of Disclosure is Requested: _____

Information about your access rights:
You have a right to an accounting of disclosures made by Mercy. This accounting will not include disclosures made for the following purposes:

- Disclosures made for treatment, payment, and healthcare operation purposes (§164.502)
- Disclosures made to the individual (§164.502)
- Disclosures made for directory purposes (§164.510)
- Disclosures made to persons involved in the individual's care (§164.510)
- Disclosures made for national security or intelligence purposes (§164.512(k)(5))
- Disclosures to correctional institutions or law enforcement officials (§164.512(k)(5))
- Disclosure made prior to April 14, 2003
- Disclosures made in response to a completed and valid authorization

I understand that the accounting will be provided to me within 60 days of receipt of the completed request unless I am notified in writing to include the reason for the delay that an extension of up to 30 days is needed.

Charges for Accounting:
Your first accounting within a 12-month period is free of charge. Thereafter, a fee may be assessed for each subsequent request within the 12-month period. You have the opportunity to withdraw or modify this request in writing in order to avoid or reduce the fee.

I want this accounting to be in the form of one of the following:

- ☐ Paper (send to address on file or alternate address above, if noted)
- ☐ Electronic, include e-mail address: _____

Where to Submit this Form:
The completed form may be returned to the Mercy location for which you are requesting the accounting. For Mercy Hospital locations, return the form to the Health Information Management/Medical Record Department. By submitting this form, I hereby request Mercy provide me with an accounting of disclosures of my health information.

_____ _____

Signature of Individual or Representative *Date*

Authority to sign if not the patient: _____

_____ _____

Mercy Co-worker Receiving Request for Accounting of Disclosure *Date Received*