FORM D

REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name: ____

Date of Birth: ______________________ SSN: XXX-XX- _______

Address where you want the accounting response sent:

____

NOTICE TO PATIENT: Your request for an accounting of disclosures of your protected health information is **only** applicable to the information maintained by the Alabama Department of Public Health. If you would like to request an accounting of disclosures of your protected health information created and maintained by any other health care provider, a separate request must be submitted to that provider.

REQUEST FOR ACCOUNTING OF DISCLOSURES:

I request an accounting of disclosures of the protected health information in my designated record set (medical record) from ________________ to ______________ (not to exceed six [6] years) maintained by the Alabama Department of Public Health.

I understand that the first accounting in a twelve (12) months period is free of charge, but that I can be charged a reasonable fee for any additional accountings.
I understand that the accounting must include all disclosures, **except** for disclosures:

- To carry out treatment, payment, and health care operations.
- Incident to a use or disclosure permitted by the Privacy Regulations.
- Pursuant to the individual's authorization.
- To persons involved in the individual's care or for a facility directory.
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials to provide them with information about a person in their custody.
- As part of a limited data set.
- That occurred prior to the compliance date.

_____________________________________ ____________________

Signature [Title, if legal representative]* Date

*May be requested to submit evidence of representative status.

**********************Retain for minimum of 6 years**********************