Attachment A

Request for Accounting of Disclosures Form

Patient Information

Field	Information
Patient Full Name	____
Medical Record Number (if known)	__________________________________
Date of Birth	____ / ____ / ______
Address	____
City / State / ZIP	____
Telephone Number	____
Email Address (optional)	____

Request Details

I am requesting an **Accounting of Disclosures of my Protected Health Information (PHI)** made by Faith Health, in accordance with HIPAA regulations.

Time Period Requested

(Disclosures may be provided for up to six (6) years prior to the date of this request.)

☐ From: ____ / ____ / ______
☐ To: ____ / ____ / ______

If no dates are listed, Faith Health will provide an accounting covering the maximum allowable six (6) year period.

Delivery Preference

Please indicate how you would like to receive your accounting:

☐ Paper copy mailed to address above
☐ Secure electronic copy (if available)
☐ Pick-up in person (photo ID required)

Fees Acknowledgment

- The **first accounting request within a 12-month period is free of charge**.
- A **reasonable cost-based fee** may apply for additional requests within the same 12-month period.

☐ I understand that if a fee applies, I will be notified in advance and may withdraw or modify my request.

Signature Authorization

I understand that this request applies only to disclosures subject to accounting under HIPAA and does **not** include disclosures made for treatment, payment, or healthcare operations.

By signing below, I certify that I am the patient identified above or the patient's legally authorized representative.

Signature	Date
____	____ / ____ / ______

If Signed by Personal Representative

Field	Information
Representative Name	____
Relationship to Patient	____
Documentation Provided (e.g., POA, Guardianship)	☐ Yes ☐ No

For HIM Use Only

Field	Information
Date Request Received	____ / ____ / ______
Request Verified by	____
Due Date (60 days)	____ / ____ / ______

Extension Applied	☐ Yes ☐ No
Extension Notice Date	____ / ____ / ______
Accounting Completed Date	____ / ____ / ______
Fee Charged	☐ Yes ☐ No
Processed By (Title)	____

Submission Instructions

Completed forms may be submitted:

- In person to the **HIM/Medical Records Department**
- By mail to Faith Health Medical Records
    - 2600 West Norfolk Avenue, Suite 200

      Norfolk, NE 68701
- By approved secure electronic method (if available)

Patients with questions may contact the HIM Department during normal business hours.