KootenaiHealth

Request for an Accounting of Disclosures Form

1. **PATIENT INFORMATION**

Date of Request:____________________Medical Record Number**:** ______________________________

Name: __________________________________Date of Birth: ____________________________

Telephone Number: ________________

Address: ____

Address to send Accounting of Disclosure (if different than above):

____

2. **DATES REQUESTED**

I would like an accounting of all disclosures for the following time frame. **Please note:** the maximum time frame that can be requested is six years prior to the date of your request.

From: _____________________________________ To: ____________________________________

3. **FEES**

There is no charge for the first request for accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is **$25.00.**.

4. **RESPONSE TIME**

I understand that the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Signature of patient/legal representative ________________________________ Date ______

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5. **THIS SECTION FOR HEALTH CARE ORGANIZATION USE ONLY**

Date request received: ___________________ Date accounting sent: ______________

Requester verified by which method? ____

Extension requested: __ no __ yes If yes, give reason: ___________________________

Patient notified in writing on this date: _____________ Staff member processing: _______

____ Kootenai Health

____ Kootenai Outpatient Imaging

____ Kootenai Clinic

____ Heart Clinics Northwest