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 _____.

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 _____

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