Patient Name: _____ DOB: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Dates of accounting: From: _____ To: _____

Information About Your Privacy Right:
You have a right to an accounting of disclosures of protected health information that CHI Franciscan Health has made. This accounting will not include disclosures made for the following purposes:

- When a completed and valid authorization has already been obtained;
- To carry out treatment, payment or health care operations;
- Requests for your own protected health information;
- For directory purposes, to persons involved in your care, or other notification purposes;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officals;
- That occured six years prior to the date of this request;
- As part of a limited data set.

We will respond to your request for access within 60 days from the time we receive this completed form. In certain situations we may require additional time to complete your request, but if we do, we will tell you in writing of the reasons for the delay and the date by which you will receive the accounting.

Charges for Accounting
Your first accounting within a 12-month period is free of charge. Thereafter, there is a fee 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. All fees are requested to be paid in full by check or money order made out to _____ .

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 email address: _____

Where to Submit this Form
You must submit this form to CHI Franciscan Health Information Management Department
HIM Central Office - St. Joseph Medical Center, Mailing Address: P.O. Box 2197, MS 01-42, Tacoma, WA 98401-2197.
Department Telephone: 253-426-6673 (127-6673)
Department FAX: 253-426-6750 (127-6750)

By submitting this form, I hereby request CHI Franciscan Health to provide me with an accounting of disclosures of my health information made by CHI Franciscan Health.

_____ _____ _____
Signature of Individual or Representative Date Time

FOR CHI FRANCISCAN HEALTH USE ONLY:

Accounting of disclosure request has been:

Date Request Received: _____ ❑ Approved ❑ Denied

Type of photo identification verified: Driver's License _____ Military I.D. _____

Other: _____ Initials: _____ Date: _____
(Please specify)

CHI Franciscan Health

597860

(04/02/15)

REQUEST FOR ACCOUNTING OF DISCLOSURES