

Patient name			
MHN	DOB	Age	Gender

**Accounting of Disclosures****Release of Information Request**

Request date (month/day/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

I would like an accounting (list) of disclosures of my health information made by Marshfield Clinic from (insert dates) \_\_\_\_\_ to \_\_\_\_\_.

Upon receipt of a written request, Marshfield Clinic will provide the requestor with an accounting of all accountable disclosures during the six (6) year period immediately prior to the date of the request for an accounting.

I would like this accounting to be mailed/mailed to me at the following address:

I understand that the accounting of disclosures I have requested will **not** include the following types of disclosures:

- Disclosures to carry out my treatment, payment and health care operations activities
- Disclosures to me or my legal representative
- Disclosures for which I signed a written authorization
- Disclosures to persons involved in my care or other notification purposes
- Disclosures for national security or intelligence purposes
- Disclosures to correctional institutions or law enforcement officials having lawful custody of me
- Disclosures made as part of a limited data set for public health, research or health care operations activities

I further understand that Marshfield Clinic will provide me with the first accounting of disclosures in any twelve (12) month period without charge but Marshfield Clinic may impose a reasonable fee for each subsequent request I make for an accounting of disclosures within the same twelve (12) month period.

\_\_\_\_\_  
Patient signature (Person authorized to consent for patient)      \_\_\_\_\_ (Relationship to patient)      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Signature date (m/d/y)      \_\_\_\_\_ Phone number

**Send completed request to: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449**  
**Fax: 715-221-6992      E-mail: [medicalrecords@marshfieldclinic.org](mailto:medicalrecords@marshfieldclinic.org)**

**FOR MARSHFIELD CLINIC INTERNAL USE ONLY**

Date received (month/day/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

 Accepted       Denied

 Temporarily suspended of right to accounting based on written or oral statement from a health oversight agency or law enforcement official

 \_\_\_\_\_  
 \_\_\_\_\_

Comments:  Individual was informed of denial in writing (attach letter of communication)

\_\_\_\_\_  
Staff member signature/title      \_\_\_\_\_ Date (month/day/year)