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 Health System from (insert dates) _____ to _____.

Upon receipt of a written request, Marshfield Clinic Health System 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/emailed 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 Health System will provide me with the first accounting of disclosures in any twelve (12) month period without charge but Marshfield Clinic Health System 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 Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

FOR MARSHFIELD CLINIC HEALTH SYSTEM 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)

