Marshfield Clinic Health System

Patient Name:	MRN:	DOB:	Sex:

Accounting Disclosures Request Form

Date of Request: _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Email _____

Send Accounting of Disclosure Report to me by:

❑ Email _____ ❑ Mail → ❑ send to address above ❑ send to address below

Address _____ City _____ State _____ Zip _____

Dates Requested	I am requesting an accounting (list) of disclosures of my health information made by Marshfield Clinic Health System for the following time period. *(**Please note:** the maximum timeframe that can be requested is 6 years prior to the date of request)* **Start Date:** _____ **End Date:** _____ I understand that the accounting of disclosures I have requested will **not** include the following types of • Disclosures to carry out my treatment, payment or health care operations activities • Disclosures to myself or my legal representative • Disclosures for which I signed a written authorization • Disclosures to person involved in my care or other notification purposes • Disclosures to 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
Fees	• **First request in a 12-month period** = Free • **Subsequent Requests within the same 12-month period** = a reasonable fee may be imposed for each request

I understand that there may be a fee for the accounting of disclosure and I wish to proceed. I also understand that the accounting will be provided to me within 60 days unless I am notified that an extension of up to 30 days is needed.

Patient signature _____ Date/Time _____ Printed name _____

Signature of Authorized Person _____ Date/Time _____ Printed name _____

❑ Parent of minor ❑ Court appointed guardian/conservator - include legal documentation

Mail Copies to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
ATTN: Health Information Management, HM2

Fax Copies to: 715-389-0564

Email Copies to: himroiadmrestrevreq@marshfieldclinic.org

For Marshfield Clinic Health System Internal Use Only Date Received by HIM: _____ Date Sent: _____

Extension Requested: ❑ Yes ❑ No Reason _____

Status: ❑ Accepted ❑ Denied ❑ Temporarily suspended of right to accounting disclosure on written or oral statement from a health care oversight agency or law enforcement official

❑ Individual informed of denial in writing (attach letter of communication)

Staff member signature _____ Date/Time _____ Printed name and Title _____

