

Patient Name	:		MRN:	DOB:	Sex:
Accounting	Disclosures Re	quest Form			Page 1 of
Date of Re	quest:				
Patient Name				Date of Birth	
Address		City		State	Zip
Phone #		Ema	ail		
	•	re Report to me by:			
Email _			Mail → sei	nd to address above sen	
Address	•	City		State	Zip
Dates Requested	the following time pe (Please note: the management of the management)	riod. aximum timeframe that ca	n be requested is 6 End Date:	years prior to the date of reque	est)
	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 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 national security of 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				
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