Request for Accounting of Disclosures of Protected Health Information

FLORIDA DEPARTMENT OF ELDER AFFAIRS
4040 ESPLANADE WAY
TALLAHASSEE, FLORIDA 32399-7000

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request an accounting of disclosures of health information that pertains to you.

REQUEST SECTION

I, _____(Patient name) hereby request an accounting of disclosures of my protected health information that have occurred over the last _____.
(Time Period - Up to 6 years)

_____ _____
Signature Date

REQUEST PROCESSING SECTION - INTERNAL USE ONLY

This section is to be completed by the reviewer:

Date received:	**Reviewed by:**
Chief Privacy Officer:	**Review Date:**

The requested disclosure accounting was processed on _____.
(Date)

_____ _____
Signature Date