REQUEST FOR AN ACCOUNTING OF DISCLOSURES

PATIENT INFORMATION

Date of Request: ___________________________ Patient Number: ___________________

Name: ____ Date of Birth: ___________________

Address: ____

____

Address to send accounting of disclosures (if different from above):

____

____

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note: your request can be for a date no earlier than April 14, 2003, and the maximum time frame that can be requested is six years.*

From: ________________________________ To: ___________________________________

FEES

There is no charge for the first accounting request in a 12-month period. For subsequent requests in the same 12-month period, SSM Health Dean Medical Group may charge a reasonable fee. I understand that there is (check one):

_____ No fee for this request

_____ A fee for this request, and I wish to proceed.

RESPONSE TIME

I understand the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

____ __________________________

Signature of Patient or Legal Representative Date

FOR SSM HEALTH DEAN MEDICAL GROUP INTERNAL USE ONLY

Date request received: _________________ Staff member processing request: ________________________

Response deadline: ____________________

Extension requested: ____Yes ____No If yes, give reason ____________________________________

Patient notified in writing of extension on this date: ________________

Approval By Privacy Officer: _________________________ (signature) Date Approved: ______________

Date Accounting of Disclosures sent: ____________________