Request for an Accounting of Disclosures

Date of Request: ____________________

Patient Name: _______________________________Date of Birth: _________________Record # _________

Address ____

City/State/Zip ____

Telephone __________________________________ Fax Number ___________________________________
(Include area code) *(Include area code)*

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

____

Disclosures made directly to you as well as those made for treatment, payment, healthcare operations, and those made pursuant to your signed authorization will be excluded from this disclosure.

I would like an accounting of disclosures for the following time frame:

From: ____________________ **To:** ____________________

(Note: the maximum time frame that can be requested is six years prior to the date of request, but not before April 14, 2003.)

Fees:
First request in a 12-month period: Free
Subsequent requests: $5.00 per year

The fee for this request will be: $ _________

Name of Patient or Personal Representative *(PLEASE PRINT)* ____

Signature of Patient or Personal Representative: ____ Date: _____
(If Personal Representative, include a description of authority to act for patient)

Return this completed form to:
Privacy Officer - Gerald Champion Regional Medical Center
2669 North Scenic Drive
Alamogordo, NM 88310
If you have any questions, please contact the Privacy Officer directly at 575-443-7857

For GCRMC Use Only:

Date Received: ___________ Date Sent: __________ Employee processing request: ____________________

Patient notified of fee: ☐ No ☐ Yes ☐ N/A

Patient withdrew/modified request (circle one)

Modified request includes the following period ____________________________

Extension Requested: ☐ No ☐ Yes, Reason ____