LABWORKS

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

PATIENT INFORMATION

Date of Request: _____

Name: _____ Date of Birth: _____

Address: _____

_____

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

_____

_____

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note: the maximum time frame that can be requested is six years prior to the date of your request.*

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, the charge is $__10.00___. I understand that there is (check one):

_____ No fee for this request

_____ A fee for this request in the amount specified above 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 YOUR HEALTH LABORATORY USE ONLY

Date request received: _____ Date accounting sent: _____

Extension requested: ____ Yes ____ No

If yes, give reason:

_____

Patient notified in writing on this date: _____

Privacy Officer Signature: _____