ADDRESSOGRAPH

NH2542

NORTHSIDE HOSPITAL, INC.

English - Spanish - Korean

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

_____

As a patient, you have the right to receive an accounting of disclosures of your health information that we have made for purposes other than treatment, payment or health care operations. This request only applies to the health care provider office identified above. The first accounting you request within a 12-month period will be provided free of charge. For additional accountings during the same 12-month period, you may be charged for the costs of providing the list; however we will notify you of the cost involved and you may choose to withdraw or modify your request.

Please specify the dates to which this accounting request applies: _____ to _____. You may not request an accounting for disclosures made more than six (6) years prior to the date of this request. You understand that under the federal privacy regulations (HIPAA) certain disclosures will not be included in this accounting.

_____ _____

Signature of Patient or Legal representative Print name

_____ _____

Date Relationship to patient

_____ _____

Interpreter (if applicable) Reason patient unable to sign

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice manager.

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

REQUEST FOR ACCOUNTING OF CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION

Reorder #NH2542 **U**
Piedmont Graphics 03/11/15

Original: Chart