REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Contact Person: HIPAA Privacy Officer, HNI (as an Affiliated Covered Entity)

Contact Phone, Email and Fax: phone - (512) 730-3060 ext. 281, email - compliance@hnihc.com, fax - (737) 273-8520

Patient Name: _____

Date of Birth: _____

Name of person submitting this request (if other than patient):

_____

Relationship to Patient: _____

Telephone #:_____ **Email:** _____

Address: _____

Please list the dates for which you are requesting an accounting (may not be more than six (6) years prior to the date of your request):

From _____ To _____

If you wish to limit the accounting to those disclosures made to a specific person or entity, please identify that person or entity here. If this section is left blank, an accounting of *all* disclosures made during the time period listed above (except those for which we not required to account for) will be provided:

_____

_____

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____