



**REQUEST FOR ACCOUNTING OF DISCLOSURES OF  
PROTECTED HEALTH INFORMATION**

**PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 13**

1. Today's Date \_\_\_\_\_

2. Patient's Name \_\_\_\_\_

3. Patient's Date of Birth \_\_\_\_\_

4. Patient's Medical Record Number (if known) \_\_\_\_\_

5. Patient's Social Security Number \_\_\_\_\_

6. Describe the information you are requesting an accounting of: \_\_\_\_\_  
\_\_\_\_\_

7. Date(s) of the information you are requesting an accounting of: \_\_\_\_\_

8. What is the reason for this request? \_\_\_\_\_  
\_\_\_\_\_

9. Signature of Patient \_\_\_\_\_

10. Signature of Patient's Legal Representative \_\_\_\_\_

11. Date \_\_\_\_\_

12. Printed Name of Patient's Legal Representative \_\_\_\_\_

13. Relationship to Patient \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW**

Access to the requested PHI has been:  Granted  
 Denied

If denied, indicate reason for denial: \_\_\_\_\_  
\_\_\_\_\_

Signature of Authorized Individual \_\_\_\_\_

Date \_\_\_\_\_

Printed Name and Title of Authorized Individual \_\_\_\_\_