

Request for Accounting of Disclosure of Protected Health Information (PHI) Form

For Patients Requesting Accounting of Disclosure of Protected Health Information (PHI)

Instructions: Please complete this form to request accounting of disclosure of protected health information. Submit the completed form to the Privacy Office for review and approval at Privacy@closeKnit.com

Patient Information

Full Name:	_____
Date of Birth (MM/DD/YYYY):	_____
Medical Record Number:	_____
Contact Number:	_____
Email Address:	_____
Facility Address:	_____
Facility Phone Number:	_____

Request Details

- **Please provide the time frame of the Accounting of disclosure of your medical records**

- **Please provide additional information regarding the disclosure you are requesting**

Patient Authorization

I hereby request an Accounting of Disclosures of my Protected Health Information (PHI) as maintained by the above-named organization. I understand that this accounting will include certain disclosures of my PHI made by the organization, as permitted or required under applicable law. I also understand that this accounting will not include disclosures made for treatment, payment, or healthcare operations, or other disclosures exempt under HIPAA regulations.

Patient Signature:	_____
Date:	_____

Privacy Officer Review & Approval

Privacy Officer Name:	_____
Review Date:	_____

Decision:	Approved	Denied
Comments/Conditions (if any):		
Privacy Officer Signature:		