# REQUEST FOR ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION

You have the right to request an accounting of certain disclosures of your Protected Health Information (PHI). Your request must be made in writing. Your request may state a time period but the time period cannot be longer than six years from the date you submit your request. Your request should indicate in what form you want the list (e.g. paper, electronically).

**Patient Information:**

Name: ____________________________________________ Date of Birth: ___________________________

Address: _____________________________________________________________________________________

City State Zip

Phone: ___________________________________ Email: _______________________________________________

**Request:**

☐ All disclosures made during the last six (6) year period prior to the date of this request.

☐ All disclosures made during the following time period (Not to exceed the last six (6) year period)

___________________________ through ________________________

Disclosures should be sent: ☐ Mail ☐ Electronically (email provided above and sent secure)

You understand that the first accounting in any 12-month period, will be provided to me at no cost. For any additional accounting requested within the same 12-month period, a reasonable fee may be charged.

Astria Health is not required by State and Federal law to include any of the following disclosures of your protected health information in an accounting to you for the following reasons:

- To carry out treatment, payment, and health care operations;
- To the patient of health care information about him or her;
- Incident to a use or disclosure that is otherwise permitted or required;
- Pursuant to an authorization where the patient authorized the disclosure of health care information about himself or herself;
- Of directory information;
- To persons involved in the patient's care;
- For national security or intelligence purposes if an accounting of disclosures is not permitted by law;
- To correctional institutions or law enforcement officials if an accounting of disclosures is not permitted by law; and
- Of a limited data set that excludes direct identifiers of the patient or of relatives, employers, or household members of the patient.

**Signature:**

Patient/Representative: ____________________________________________________ Date: __________________

Legal Authority: __________________________________________________________________________

☐ Self ☐ Parent ☐ Legal Guardian ☐ Medical Power of Attorney

**Please attach Legal Documentation if you are the Legal Guardian or holder of Power of Attorney

**<u>This form can be sent to us by Mail, Fax or Email:</u>**

**Astria Health – Health Information Dept. 1016 Tacoma Ave, Sunnyside, WA 98944**

**Phone: 509-837-1636, Fax: 509-837-1637, Email: ROI@Astria.Health**

**Monday – Friday, 8:00am – 4:30pm, Closed all major Holidays**