REQUEST FOR ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION

THE OREGON CLINIC

Please send this form to:

The Oregon Clinic Medical Records Department (ATTN: Clinical Content Manager) by:
FAX: (503) 935-8404 or **E-MAIL***: compliance@orclinic.com or **MAIL**: 541 NE 20th Ave. Ste. 225, Portland, OR 97232
Communications via e-mail are not secure

PART A: INDIVIDUAL TO COMPLETE THE FOLLOWING INFORMATION (please print):

Name (last, first, middle): _____

Address: _____

Telephone No.: _____ Date of Birth: _____

Medical Record No.: _____

REQUEST:

I request an accounting of disclosures of my health information as follows (**check one**):

☐ for all disclosures, subject to HIPAA* accounting requirements, made during the six (6)-year period prior to the date of this request, but not including disclosures made before April 14, 2003.**

☐ for all disclosures, subject to HIPAA accounting requirements made during the following time periods: _____ through _____ (and not including disclosures made before April 14, 2003).

I understand that any accounting made during any twelve (12)-month period will be provided to me at no cost. For any additional accounting requested within the same twelve (12)-month period, The Oregon Clinic (TOC) may charge a reasonable fee.

Date: _____

Signature of Patient/Legal Representative: _____

Printed name of Legal Representative: _____

*HIPAA means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

**Effective date to comply with the HIPAA Privacy Rule.

PART B. TOC STAFF TO COMPLETE THE FOLLOWING:

Date of receipt of request: _____

Person receiving request: _____

Date accounting is sent to Individual: _____

Person sending accounting: _____

Method by which accounting was delivered: ☐ mail ☐ in-person ☐ electronic means ☐ other: _____

Staff comments: _____

Signature of staff (name/title/dept.): _____