Restorative THERAPIES
Your advocate for life.

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PHI

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #: _____ **Email:** _____

ACCOUNTING REQUEST

Date(s) of service: _____ ☐ All dates of service

AUTHORIZATION

By signing below, I understand that:

- This accounting for disclosures will include all disclosures of protected health information (PHI) *except* for disclosures made:
  - for treatment, payment, or health care operations
  - pursuant to my written authorization
  - to myself and/or my authorized representative
  - more than six (6) years prior to the date of this request
- The requested accounting of disclosures will be provided to me within 60 days of this request.
- I may be charged for this information if I have previously requested an accounting of disclosures within the last twelve (12) months.

Signature of Patient or Representative*: _____ **Date:** _____

Name of Representative: _____ Relationship to Patient: _____

**** If not signed by the patient or parent of a minor child, authorizing documentation is required.***

(e.g. Power of Attorney or Legal Guardianship)