bellinhealth

3/03; Reviewed 3/04

REQUEST FOR AN ACCOUNTING OF DISCLOSURES FORM

PATIENT INFORMATION:

Date of Request: _____

Name: _____ Date of Birth: _____

Address: _____

_____

Address to Send Disclosure Accounting (if different from above):

_____

_____

DATES REQUESTED:

I would like an accounting of disclosures for the following timeframe.
Please Note: *The maximum timeframe that can be requested is six years prior to the date of your request, and cannot predate April 14, 2003 except for Bellin Psychiatric Center or Bellin Behavioral Health records.*

From: _____ To: _____

SITES REQUESTED:

Please check the Bellin Health sites at which you have been seen as a patient and would like included in the disclosure accounting:

- ❒ Bellin Hospital
- ❒ Bellin Psychiatric Center
- ❒ Bellin Home Health
- ❒ Bel-Regional
- ❒ Bellin Behavioral Health
- ❒ Bellin Retail Pharmacy
- ❒ Bellin Medical Group Clinic(s). Please name which clinic(s): _____

FEES:

There is no charge for the first disclosure accounting request in a 12-month period. For more than one request in the same 12-month period, there will be a charge of $30 for processing this request.

RESPONSE TIME:

I understand the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed. I understand that if it has been less than 12 months since my last request I will be charged a fee of $30 for processing this request.

_____ _____

Signature of Patient or Legal Representative Date

FOR BELLIN HEALTH USE ONLY:

Date Request Received: _____ Date Accounting Sent: _____

Extension Requested: ❒ Yes ❒ No

Contact the Team Leader of Medical Records at Bellin Hospital or Bellin Psychiatric Center for assistance in responding to the request.

SEND A COPY OF THIS REQUEST TO THE BELLIN HEALTH PRIVACY OFFICER