

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION FORM

Patient Name: _____ ID# _____ Date: _____

There are some situations in which [insert physician/organization name] is required or permitted by law to disclose your health information to persons outside of our office. In response to your request, we are providing you with this accounting of disclosures we have made of your information.

We have made no disclosures of your health information that require an accounting.
 We have made the following disclosures

Disclosure Date	<u>Recipient Name</u>	Recipient Address	Description of PHI Disclosed	Purpose of Disclosure	Frequency of Disclosure/Date of Last Disclosure

This accounting does not include disclosures we have made to carry out treatment, payment or health care operations or disclosures you have specifically authorized. It also does not include any disclosures the law exempts from our accounting requirements.

If you have questions about this accounting, please contact [insert name and title of contact person] at [insert phone number].