



Philadelphia FIGHT Community Health Centers
REQUEST FOR ACCOUNTING DISCLOSURES

I, _____, request an accounting of Disclosures of my health care information, excluding Disclosures that are authorized, or Disclosures made for treatment, payment, or health care operations.

Patient First and Last Name: _____ DOB: _____

Phone Number(s) by which you can be contacted about this request:

Time period for which you would like an accounting (may not be more than 6 years):

From: _____ To: _____

You will receive a response to your request in writing within sixty (60) days.

If FIGHT is unable to respond with an accounting within sixty (60) days of your request, you will receive a statement within those sixty (60) days informing you when you will be given the accounting. In any case, the accounting will be provided to you within no more than ninety (90) days of the receipt by FIGHT of your original request. FIGHT may temporarily hold a Patient's right to receive an accounting of Disclosures of her/his medical information to a health oversight agency or law enforcement agency if the accounting would be reasonably likely to make the agency's activities more difficult.

This Request was made by: _____
Printed Name of Requestor-Patient or Legally Authorized Representative

Signature of patient or patient's Legally Authorized Representative
(Form MUST be completed before signing.)

Date

Printed name of Patient's Legally Authorized Representative:

Description of Legal Authority to act for the Patient:

FOR INTERNAL FIGHT USE ONLY

Staff must email this request form to FIGHT's Privacy Officer at privacy@fight.org, within ten (10) days of receipt of request.