PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

For Which State: ☐ Alaska ☐ California ☐ Montana ☐ New Mexico
☐ Oregon ☐ Texas ☐ Washington

Please forward this form to the Providence Health & Services at the following address:

Providence Health & Services
Attn: Release of Information
P.O. Box 4950
Portland, OR 97208
Email: ROIHIMpatientrights@r1rcm.com
Fax: (503) 215-7663

PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name: _____ DOB: _____

I request that Providence Health & Services (PH&S) provide me with an accounting of the disclosures of my protected health information made by PH&S for the following time period:

_____ to _____ (No more than six years prior to the date of request)

Please provide me with the accounting via the following (check one):

☐ Fax: _____ ☐ Email: _____

☐ Paper - Address: _____

I understand that PH&S is not required to tell me about the following types of disclosures:

- Disclosures for purposes of treatment, payment and health care operations; or as part of a limited data set
- Disclosures to me or authorized by me
- Disclosures for use in the hospital's directory
- Disclosures to persons involved in my care
- Disclosures for notification purposes
  (to notify family members/personal representatives of my location, general condition or death).
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- Disclosures made more than six years prior to the date of the request
- Disclosures otherwise permitted or required by federal or state law.

I understand that my right to an accounting of some or all disclosures may be suspended by law enforcement or government officials under limited circumstances.

I understand that I am entitled to an accounting free of charge every 12 months, and that I may be charged if I request any additional accountings within the same 12 months.

I understand that I will be notified of the cost involved and will have the opportunity at that time to withdraw or modify my request before any costs are incurred.

SIGNATURE: _____ DATE: _____

(If signed by a personal representative of the patient, please complete the following.)

Personal representative's name: _____

Relationship to patient: ☐ Parent ☐ Other: _____

☐ Legal guardian* ☐ Power of Attorney for Healthcare*

* Attach legal documentation if you are the legal guardian or Power of Attorney for Healthcare

If you believe your privacy rights have been violated, you may file a complaint with this facility or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

For Internal Use Only

Date Received: _____ Received by: _____ MRN: _____

Date Entered into Accounting of Disclosures Database: _____

SUBMIT