CENTRAL OHIO PRIMARY CARE

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: _____ **Date of Birth:** _____
Last First Middle (M/D/Y)

Address: _____
Street City State Zip

Telephone Number Where You Can Be Reached: _____

I hereby request an accounting of disclosures of my protected health information. I understand the list will not include disclosures made: 1.) for purposes of payment, treatment or health care operations; 2.) to me, my caregivers or my legal health care representative; 3.) for which I or my legal health care representative provided a written authorization; 4.) for national security or intelligence purposes; 5.) to correctional institutions or law enforcement officials; 6.) for purposes of research or public health when direct patient identifiers are not used; 7.) as required by law; 8.) to a health oversight agency in certain circumstances; 9.) before April 14, 2003. I also understand that, by law, the maximum period the list will cover is 6 years immediately preceding this written request. I understand that the first request for an accounting of certain disclosures in a 12 month period will be provided at no charge and, for any subsequent requests for an accounting of disclosures in a 12 month period, I will be charged a reasonable fee based on COPC's cost for the labor associated with preparing the accounting of disclosures.

Date of Request:_____ **Physician:** _____ **Office Location:** _____

Beginning Date (cannot be prior to April 14, 2003): _____ **Ending Date:** ___

COPC may accept or deny your request for an accounting of certain disclosures. If your request is denied, you will be informed in writing of the reason(s) for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted or denied within sixty (60) days of receipt of this request. COPC can extend the response period for up to an additional thirty (30) days by notifying you in writing.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

For COPC Use Only – forward to COPC Compliance Officer

Date Request Received: _____ **Accounting Has Been:** □ Accepted □ Denied

If denied, check reason(s) for denial:

- □ The Request for Accounting Form was not complete. You may complete the missing information highlighted above and resubmit your request to: COPC Compliance Officer, 570 Polaris Parkway, Suite 250, Westerville, Ohio 43082
- □ The request covers a period greater than six years preceding the request.
- □ The request beginning date is prior to April 14, 2003.
- □ The request is the second or more in a 12 month period and patient is unwilling to pay fee for preparation of accounting of disclosures.

Comments: _____

Patient Notified By: □ Regular Mail □ Courier □ Certified Mail **Date Sent:** _____

_____ _____ _____ _____
Signature of COPC Authorized Representative (Name/Title) **Date** **Signature of Health Care Provider (if applicable)** **Date**

Form Revision: 9/23/2013