KEYTONE HEALTH

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

PATIENT INFORMATION

Date of Request: ______________________ Medical Record No.: __________________

Name: ____ Date of Birth: __________________

Address: ____

____

Address to send disclosure accounting (if different from above):

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DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note: the maximum time frame that can be requested is six years prior to the date of your request.*

From: ____________________________ To: ____

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.

____ ________________________

Signature of Patient or Legal Representative Date

FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: ____________________ Date accounting sent: ___________________

Extension requested: ____ Yes ____ No

If yes, give reason: ____

Patient notified in writing on this date: __________________

Staff member processing request: ____

Forward To: **Keystone Health**
HIM- Release of Information Department
111 Chambers Hill Drive, Suite 200 Chambersburg, PA 17201
Phone Number: (717) 709-7960 Fax Number: (717) 217-1937
Email: khc-him@keystonehealth.org