

**REQUEST FOR ACCOUNTING OF DISCLOSURES**

<b>Date of Request:</b>	<b>Patient Name:</b>
<b>Date of Birth and SSN:</b>	<b>Address:</b>

**Address to Send Disclosure Accounting (if different than above):**

**DISCLOSURE ACCOUNTING REQUESTED FROM THE FOLLOWING:**

Palmetto Health Baptist  
 Health Information Management Department  
 Taylor at Marion Street  
 Columbia, SC 29220

**DATES REQUESTED**

I would like an accounting of all disclosures for the following time frame\*:

From: \_\_\_\_\_ To: \_\_\_\_\_

\*Please Note: The time frame that may be requested is limited to those requests on or after April 14, 2003

**FEES**

First request in 12 month period: Free  
 Subsequent request (cost-based fee): \$ 25.00

I understand that there is a fee for subsequent requests within the same 12-month period and wish to proceed if applicable. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed. No refunds available.

\_\_\_\_\_

**Signature of Patient/Legal Representative** **Date**

**FOR ORGANIZATIONAL USE ONLY**

<b>Date Received:</b>	<b>Date Sent:</b>
<b>Extension Requested:</b>	<b>If "Yes," Reason:</b>
<b>Date Patient Notified of Extension (attach copy):</b>	<b>Date Accounting of Disclosure Sent to Patient:</b>
<b>Staff Member Processing Request:</b>	