

REQUEST FOR ACCOUNTING OF DISCLOSURES

Date of Request:	Patient Name:
Date of Birth and SSN:	Address:

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

DISCLOSURE ACCOUNTING REQUESTED FROM THE FOLLOWING:

Palmetto Health Richland
 Health Information Management Department
 Five Richland Medical Park
 Columbia, SC 29203

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

Date Received:	Date Sent:
Extension Requested:	If "Yes," Reason:
Date Patient Notified of Extension (attach copy):	Date Accounting of Disclosure Sent to Patient:

Staff Member Processing Request: