Request for Accounting of Disclosures

This form is used for an Individual to request an accounting of disclosures of their protected health information (PHI). Only the Individual or the Individual's Personal Representative may obtain an accounting of the disclosures of an Individual's PHI. (45 CFR § 164.528).

I request HealthTrust provide an Accounting of Disclosures of my protected health information. I request the Accounting include all disclosures made between _____ and _____ (enter dates). HealthTrust is required to provide disclosures made over the past six (6) years unless a shorter time period is indicated.

By signing this form,

- I understand that HealthTrust has 60 days to respond to this request.
- I understand that if the protected health information was disclosed 1) for treatment, payment or healthcare operations; 2) to notify or assist my family or other persons involved in my care; 3) for national security intelligence; 4) to correctional facilities or law enforcement authorities having custody of me; or if the disclosure 5) was previously authorized by, or released to, me or my personal representative; 6) consisted only of de-identified information; 7) occurred more than six (6) years before the date of this request; 8) is incident to a use or disclosure otherwise permitted or required; or 9) was part of a limited data set, then the disclosure will not be included in the accounting.
- I understand the Accounting of Disclosure will include the date of the disclosure; the name, and if available, the address of the person or entity receiving the information; a description of the information disclosed; and a brief statement of the purpose of the disclosure.
- I understand HealthTrust must temporarily suspend my right to an Accounting of Disclosure if directed to do so by a health oversight agency or law enforcement official.
- I understand HealthTrust must provide the first accounting in any 12 month period without charge; however, HealthTrust may impose a reasonable, cost-based fee for each subsequent request for an accounting by me or my Personal Representative within the 12 month period.

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER Reference: HIPAA Individual Rights Policy.	
Name of HealthTrust Workforce Member Receiving Form:	Date: