



Request for Accounting of Disclosures of Health Information

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____ - ____ - ____ Medical Record #: _____ Phone: _____

Address: _____ City: _____ ST: ____ Zip: _____

I request an accounting for disclosures of my health information for the period:

From: _____ To: _____

I understand that this accounting for disclosures will include disclosures made only to those organizations or persons *other than*:

- to those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out your operations;
- to myself or persons involved in my care;
- pursuant to my authorization;
- for national security or intelligence purposes;
- to correctional institutions or law enforcement officials under certain circumstance; or
- those occurring prior to April 14, 2003.

I understand that my request for an accounting of disclosures will be processed within 60 days of submitting this form. I will be notified of the need for an extension of not more than 30 days to process the request, the reasons for the delay and the date when I can expect to receive the requested accounting.

Please send this accounting by:

- Paper Copy (call at number above to pick up or mail to address above)
 Email _____ or other electronic method _____

SIGNATURE OF INDIVIDUAL

DATE

OR

SIGNATURE OF PERSONAL REPRESENTATIVE

DATE

RELATIONSHIP TO INDIVIDUAL

You may submit this form

- In person: to the nearest Concentra medical center
- By mail: Concentra Privacy Office
P O Box 1438
Louisville, KY 40202-1438
- By fax: 502.508.3700
- By email: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY
Complete the section below, then

Email this request to PrivacyOffice@Concentra.com or fax to 502.508.3700
with all records referenced in the request

Staff member who received request Title Phone Date completed

Center Name Location Number

