Memorial Hermann Health System

Patient Request for an Accounting of Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address:

_____

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Dates requested:

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

From:_____ To: _____

I understand that there is no charge for an accounting of disclosures within a 12 month period. Subsequent requests are $10.00 per request.

The accounting of disclosure will be provided to me within 60 days from receipt of this document by Memorial Hermann unless I am notified in writing that an extension of up to 30 days is needed.

_____

Patient Signature and Date