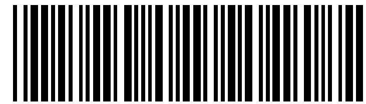
Medical Record Number

Patient Name

DOB:

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL
STANFORD, CALIFORNIA 94305



CORE • REQUEST FOR ACCOUNTING OF DISCLOSURES

I would like to request an accounting of how my Protected Health Information (PHI) was disclosed by Stanford Hospital and Clinics (SHC) and/or Lucile Packard Children's Hospital (LPCH) as required by federal regulations. I understand that SHC/LPCH **does not** have to tell me about the following types of disclosures:

1. Disclosures made prior to April 14, 2003.
2. Disclosures for purposes of treatment, payment, and health care operations.
3. Disclosures to me.
4. Disclosures from the SHC/LPCH directory.
5. Disclosures to persons involved in my care.
6. Disclosures for notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition, or death).
7. Disclosures for national security or intelligence purposes.
8. Disclosures to correctional institutions or law enforcement officials.

I also understand that the government under limited circumstances may suspend my right to an accounting of some or all disclosures.

I want an accounting of disclosures that covers the following period:

From: ______________________ To: ______________________
(Note: The time period must be no longer than six years and may not include dates before April 14, 2003)

I want an accounting of disclosures in the following form:

- ❑ Mail to: (Address) ______________________
- ❑ I prefer to pick-up the accounting. Please call me at the following phone number when it is ready to be picked up: (Phone Number) ______________________

I understand that SHC/LPCH must provide the accounting of disclosures within 60 days of my request or notify me that an extension of an extra 30 days (or less) is required to prepare it.

I am entitled to one free accounting of disclosures in any 12-month period. A fee of $50.00 will be charged for every additional request in a 12 month period.

______________________ ______________________
Signature: Patient/Parent/Personal Representative Date

If other than patient, specify relationship: ______________________

If interpreted: ______________________ ______________________ ______________________
Interpreter Signature *Print Name* *Language*

______________________ ______________________ ______________________
Date *Time* *Position/Relationship to Patient*

Send completed request form to: SHC/LPCH – Health Information Management Services, 300 Pasteur Drive, MC 5202, Stanford, CA 94305-5202.

15-2125 (4/03)