Children's of Alabama

CHILDREN'S OF ALABAMA (COA)
REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: (Please print)		**Request Date:**	
Address and phone number:		**Patient Birth Date:**	

Request for Accounting

Address to send accounting to (if different from above):		
Dates Requested For Accounting:	*Please note: The period will not be more than six (6) years and must begin on or after April 14, 2003.*	
	From:	To:
Fees:	There is no charge for the first accounting request in a twelve (12) month period. For additional requests in the same 12-month period, there is a fee. Contact the COA Privacy Officer for current fee.	

Signature of Parent/Legal Guardian/Patient

I represent that I am the parent/legal guardian/patient and have the authority to request this accounting. I understand that COA may not be able to accept this request if prohibited by law. This 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.

Parent/Legal Guardian Printed Name:_____

Parent/Legal Guardian Signature:_____**Date:**_____

Patient Signature if 19 or Older:_____**Date:**_____

Witness Signature:_____**Date:**_____

** RETURN FORM TO THE COA PRIVACY OFFICER**

Mailing Address: COA Privacy Officer, Children's of Alabama, 1600 7th Avenue South, Birmingham, AL 35233

Fax: (205) 638-2468

Email: HIPAA@ChildrensAL.org

Phone for Questions: (205) 638-5959