



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:	<i>Please note: The period will not be more than six (6) years and must begin on or after April 14, 2003.</i>		
	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