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

Patient Information

Patient Name: (Please print)		**Request Date:**	
Address:		**Birth Date:**	
Phone Number:			

Request for Accounting of Disclosures

Address to send Accounting (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 12-month period. I have been informed of the fee for additional requests in the same 12-month period.	

Signature of Parent/Legal Guardian/Patient

I represent I am the parent/legal guardian/patient and have the authority to request this accounting. I understand Children's of Alabama 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 14 or Older:_____**Date:**_____

Witness Signature:_____**Date:**_____

INTERNAL USE ONLY: Date Request Received:_____ Date Accounting Sent:_____
MRN:_____Extension Requested: ☐ Yes ☐ No
If Yes, state reason:_____Date Notified:_____
Comments:_____
Employee Processing Request:_____
MIS Initials:_____HIPAA Initials:_____