REQUEST FOR AN ACCOUNTING

I am completing this form as the (check one):

☐ Patient ☐ Parent or Guardian of Minor Patient ☐ Patient's Personal Representative

Patient's Full Name: _____

Patient's Date of Birth: _____ Telephone #: (_____) _____

Address where Accounting will be mailed to:

_____

City: _____ State: _____ Zip:_____

Disclosure Date-Range Requested: *

From: _____/_____/_____ To: _____/_____/_____
Month Day Year Month Day Year

By my signature below, I hereby request an accounting of all accountable disclosures of my/the patient's Protected Health Information that the City of Hope National Medical Center (COHNMC) or any of its business associates have made during the date range specified above.

I understand that COHNMC is not obligated to provide me an accounting of any accountable disclosures made before **April 14, 2003.***

If I need further information regarding the types of disclosures that are "accountable," I understand that I can ask COHNMC for a copy of its policy that describes what types of disclosures are "accountable." In particular, I understand that disclosures made in connection with treatment, payment and certain health care operations conducted by COHNMC are not "accountable," nor are disclosures made by COHNMC pursuant to my authorization.

I understand that if this is my first request during the past twelve (12) months for an accounting of disclosures, then I will receive my requested accounting free of charge. I understand that if I have made more than one request during the past twelve (12) months for an accounting of disclosures, then COHNMC will charge me **$25.00** per request for processing, producing and mailing my requested accounting. If this fee is unacceptable to me I do not need to complete this form, but I understand that if I don't complete this form I will not receive my requested accounting of disclosures.

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME

If Personal Representative has signed above, please indicate your relationship to the patient:
☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other

After you have completed this form please fax to (626) 301-8443, or return by mail to:

City of Hope National Medical Center
Attn: Health Information Management Services Office
Release of Information Desk
1500 East Duarte Road, Duarte, CA 91010

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