Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

(Please Print)

GUNDERSEN
HEALTH SYSTEM®

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

You have the right to an accounting of disclosures Gundersen Health System has made of your Protected Health Information (PHI). The maximum accounting period is the 6 years prior to your request, except we are not obligated to account for disclosures made before April 14, 2003.

I understand that Gundersen Health System is not required to provide me with an accounting of disclosures for the following:

1. Disclosures for purposes of treatment, payment and health care operations or as party of a limited data set;
2. Disclosures to me or disclosures authorized by me;
3. Disclosures for use in the hospital's facility directory;
4. Disclosures to persons involved in my care;
5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death);
6. For national security or intelligence purposes;
7. To correctional institutions or law enforcement officials;
8. Disclosures prior to April 14, 2003; or
9. Disclosures incident to a use or disclosure otherwise permitted or required by state or federal law.

To exercise your rights to a disclosure accounting, please specify below the date range for the accounting of disclosures you are requesting.

Date Range: From _____ To _____

You are also entitled to one free disclosure accounting each 12 months. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

☐ Please send my accounting to the following address:

_____

_____

_____

☐ I want to pick up the accounting, please contact me at the following phone number when it is ready:

_____

I request an accounting of the disclosures of my protected health information made within the date range specified above and within the 6 years prior to the date of this request (except not earlier than April 14, 2003). I understand that I am entitled to one free disclosure accounting each 12 months. I agree to pay a reasonable fee for additional accountings if I have already received one within the previous 12 months. I understand that Gundersen Health System must provide the accounting of disclosures within 60 days or inform me that they need an additional 30 days (or less) to prepare it.

_____ _____

Signature of Patient Date

_____

(If signed by authorized person, state relationship and authority to do so.)