The City of Oceanside
Patient Request for Accounting of Disclosures of Protected Health Information

Patient Name: _____Phone:_____

Street Address:

_____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

Right to Request an Accounting of Disclosures of PHI and Our Duties:

You (or your authorized representative) have the right to receive an accounting of certain disclosures of your PHI made within six (6) years immediately preceding your request. But, we are not required to provide you with an accounting of disclosures of your PHI: (a) for purposes of treatment, payment, or healthcare operations; (b) for disclosures that you expressly authorized; (c) disclosures made to you, your family or friends, or (d) disclosures made for law enforcement or certain other governmental purposes.

Request for an Accounting of Disclosures of PHI:

Below, please specify the period of time for which you are requesting an accounting of disclosures of your PHI. If you do not specify a time period, the City of Oceanside will provide an accounting of disclosures during the previous six (6) years that we were required to track.

Period of time for which I am requesting an accounting:

_____

Signature of Requestor: _____ ***Request Date:*** _____

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____Zip Code: _____