ChristianaCare

ChristianaCare Privacy Office
4000 Nexus Drive
Avenue North – Suite NW3-100
Wilmington, DE 19803
Telephone No.: (302) 623-4468
Fax No.: (302) 428-2475

REQUEST FOR ACCOUNTING OF DISCLOSURES

MR# _____

Complete this form when an individual requests an accounting of disclosures of their protected health information.

**PLEASE COMPLETE ONE FORM FOR EACH ACCOUNTING REQUESTED **

Patient/Member Name: (print)_____ Date of Birth:_____

Where should the Accounting be sent?

- o I wish to have the accounting emailed to this address:_____.
- o I wish to have the accounting mailed to this address:

_____

_____

- o Other:_____

I would like an accounting of disclosures for the following time period (specify):

Dates:_____

I am interested in disclosures of the following documents/records (specify):

Date(s) of Visit	Location, Department, Type of Service

I would like an accounting for the following reason (specify):_____

_____

Please note that the first accounting within a 12-month period will be provided without charge.

_____ _____or

Signature of Patient/Member | Telephone No. | Date

_____ _____

Signature of Legal Representative & Relationship to Patient/Member | Telephone No. | Date