Lexington Clinic

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

You have the right to request an accounting of certain disclosures of your Protected Health Information (PHI). Your request must be made in writing. Your request may state a time period, but the time period cannot be longer than six years from the date you submit your request. Your request should indicate in what form you want the list (e.g., paper, electronically). We may charge you for the costs of providing the list if you request more than one list in a 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Patient Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)
Address: _____
City State Zip Code
Telephone Number: _____
(Including area code)
Employer Name: _____Group Plan #: _____

Employee Name: _____ Last Four Digits of Social Security Number: _____

Period of time for which you wish to see the disclosures.

_____ to _____

Disclosures should be sent ☐ first class mail ☐ electronically

Unless your state has different requirements, we are not required by federal law to include any of the following disclosures of your protected health information in an accounting to you:

- Disclosures to carry out treatment, payment, and health care operations;
- Disclosures made to you or your personal representative;
- Disclosures incidental to permissible uses or disclosures of your information;
- Disclosures made to persons involved in your care or notification of next-of-kin or family members;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody;
- Disclosures made pursuant to your or your representative's authorization; or
- Disclosures made more than six years prior to your request.

Print Name: _____Relationship: _____

Signature: _____ Date: _____

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the patient (e.g., Health Care Power of Attorney). Please send this form to: Lexington Clinic, 1221 South Broadway, Lexington, KY 40504 Accounting of Disclosure Form, Corporate Compliance Department