Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Birthdate: _____ Medical Record Number: _____

I hereby request an accounting of disclosures of my Protected Health Information (PHI) made by Evergreen Healthcare and its business associates dating from_____through _____ The accounting period may be up to six (6) years prior to the date of my request.

I further understand that the accounting will not include disclosures made:

- For purposes of treatment, payment, or health care operations,
- To me or my personal representative
- Pursuant to my specific authorization,
- As part of a limited data set,
- From the facility's directory,
- Oral disclosures made to close family members and others involved in the individual's care,
- Made incidental to an allowable disclosure,
- For national security or intelligence purposes,
- To correctional institutions and other law enforcement agencies under the custodial exception, or
- Before April 14, 2003 which is the compliance date of the Privacy rule.

I understand that I am entitled to one (1) accounting of disclosed information at no charge every twelve (12) months. I understand that I will pay a reasonable fee of $25.00 for each subsequent accounting of disclosures within the same twelve (12) month period.

I understand that I am not legally obligated to sign this authorization in order to receive treatment.

Signature: _____ Date: _____
(If signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____
Relationship to Patient: ☐Parent ☐Legal Guardian* ☐Holder of a Medical Power of Attorney*
* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

EvergreenHealth Kirkland, WA 98034

REQUEST FOR ACCOUNTING OF DISCLOSURES
FORM ID ADM 542
Rev: 11/12

APPLY PATIENT LABEL HERE

Original – Medical Record Copy – Patient