Patient Cognitive Label

Request for an Accounting of Disclosures

DATE:

MRN:

NAME

Date of Birth:

REQUEST FOR ACCOUNTING OF DISCLOSURES

As a patient, you, your personal representative or legal guardian have the right to know who Henry Ford Health System (HFHS) has shared your protected health information (patient information) with. This is called an accounting of disclosures and includes certain patient information that has been shared by HFHS or any of its business associates.

An accounting of disclosures does not include the sharing of your patient information for the following purposes:

- Treatment, Payment, Healthcare operations;
- Disclosures made to the patient, their personal representative or guardian;
- Disclosures with authorization from the patient, their personal representative or guardian;
- Disclosures that do not require to be accounted for by law.

To receive an accounting of disclosures please complete this form. When complete, return this form by one of the following options:

- Email: HFHSMedicalRecords@hfhs.org (Please be aware that email is not secure and could be viewed in transit)
- Fax: (313) 916-3917
- Mail: Henry Ford Health System, ATTN: Supervisor, Medical Records Department
  2799 W. Grand Blvd. K1, Detroit, MI 48202

REQUESTER INFORMATION

All forms **must** be signed and dated. Incomplete forms will be returned to you and will not be processed. the requestor is the personal representative, attach certifying documentation of your status as the personal representative, such as a Durable Medical Power of Attorney or Guardianship papers.

Patient: _____ _____
(Name of Patient) (Date of Birth)

Requested by (if other than patient): _____ _____
(Personal Representative of Patient) (Relationship to Patient)

Requestor Contact Information: _____ _____
(Street Address) (City/State/Zip) (Telephone)

Patient/Requestor Signature: _____ Date: _____ Time: _____

ACCOUNTING OF DISCLOSURES REQUEST

Please provide the dates of disclosures you want us to account for:

☐ **From:**_____/_____/_____to_____/_____/_____(may not exceed 6 years)

Comments: _____

FOR HFHS USE ONLY

Processed By:_____Accounting Sent:_____Date scanned into medical record:_____

Comments: _____