



## PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

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Please forward this form to the Release of Information (ROI) Department at Swedish Medical Center. You may forward the request to the following address:

Swedish Medical Center  
Health Information Management - ROI  
747 Broadway  
Seattle, WA 98122  
Fax: (206) 320-2626

## PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I request that Swedish provide me with an accounting of the disclosures of my protected health information made by Swedish for the following time period:

\_\_\_\_\_ to: \_\_\_\_\_ (No more than six years prior to the date of request)  
Please provide me with the accounting (check one):  Paper  CD  Email

**My mailing address/e-mail address is:**

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I understand that Swedish is not required to tell me about disclosures made:

- To carry out treatment, payment and health care operations
- To me or authorized by me
- For use in the hospital's directory
- To persons involved in my care or for other notification purposes (such as for my location, general condition, or death)
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials with lawful custody of me
- As part of a limited data set
- More than six years prior to the date of the request

I understand that my right to an accounting of some or all disclosures may be suspended by law enforcement or government officials under limited circumstances.

I understand that I am entitled to an accounting free of charge every 12 months, and that I may be charged if I request any additional accountings within the same 12 months. I understand that I will be notified of the cost involved and will have the opportunity at that time to withdraw or modify my request before any costs are incurred.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(If signed by a personal representative of the patient, please complete the following.)

Personal representative's name: \_\_\_\_\_

Relationship to patient:  Parent  Other: \_\_\_\_\_  
 Legal guardian\*  Power of Attorney for Healthcare\*

\* Attach legal documentation if you are the legal guardian or Power of Attorney for Healthcare

If you believe your privacy rights have been violated, you may file a complaint with this facility or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

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**To be completed by Swedish.**

Date Received: \_\_\_\_\_ Received by: \_\_\_\_\_ Department: \_\_\_\_\_

- Response deadline has been extended. Disclosure must be completed by the following date: \_\_\_\_\_ (no later than 90 days after date request was received).
- Disclosure was provided free of charge on \_\_\_\_\_.
- Disclosure will cost \$ \_\_\_\_\_ and the patient was notified of this cost on \_\_\_\_\_.
- The patient agreed to pay the cost and the Accounting was provided on \_\_\_\_\_.
- The patient refused to pay the cost and no Accounting was provided.