

Facility Name or Logo: On-Site Solutions Physical Therapy	<i>Protected Health Information Accounting of Disclosures Request Form</i>	Revision Number: 1-2024
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Patient Name: _____

Date: _____

Date Range to be Included

I would like an accounting of disclosures of my Protected Health Information (PHI) for the following time frames. *(Please note the maximum time frame that can be requested is six years prior to the date of this request.)*

From Date		To Date	
From Date		To Date	

Fees

First request in a 12-month period:	Free
Subsequent Requests	Cost-based fee per request

I understand that there may be a fee for this accounting and wish to proceed. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Qualified Exceptions to the Accounting

I understand that, by law, On-Site Solutions Physical Therapy is not required to account for disclosures that meet the following criteria:

- The disclosure was necessary to carry out treatment, payment, and health care operations.
- The disclosure was to the patient for which the PHI was created or obtained.
- The disclosure was pursuant to a signed authorization by the patient or personal representative.
- The disclosure was for the Facility’s directory or to persons involved in the patient’s care or other notification purposes.
- The disclosure was for national security or intelligence purposes.
- The disclosure was to a correctional institution or law enforcement official.
- The disclosure occurred prior to April 13, 2003.

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

Distribution of copies: Original to patient’s Health Record, copy to patient