Request for Accounting of Disclosures of Protected Health Information

PATIENT CONTACT INFORMATION

Patient Name: ____________ Date of Birth: ____________

Phone #: ____________ Medical Record # (*optional*): ____________

Street: ____________ City: ____________ State/Zip: ____________

REQUEST

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

From: ____________ (*date*) To: ____________ (*date*)

☐ Salem Hospital ☐ West Valley Valley

I understand that I am entitled to receive an accounting of certain disclosures made by Salem Health, not including disclosures made for treatment, payment or health care operations or disclosures made previous to April 14, 2003 or other excepted purposes.

I understand that I am entitled to an accounting free of charge every 12 months, and that I may be charged if I request an additional accounting 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.

I understand I have the right to receive an accounting of disclosure of protected health information made by Salem Health in the ***six*** years prior to the date on which the accounting is requested.

____________ ____________

Signature (*If signed by a personal representative, please print the following*) **Date**

Personal representative's name: ____________

Relationship to Patient: ____________

Please return completed form to: **Salem Health Privacy Officer**
Corporate Integrity Office
P.O. Box 14001
Salem, OR 97309-5014

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