Date of Request: _____

Member's Name: _____ DOB: _____

Member's Address: _____

Medical ID Number: _____

Address to send disclosure accounting (if different from above):

_____

Dates Requested

I would like an accounting of all disclosures for the following timeframe:
(Please note: The maximum timeframe that can be requested is six years prior to the date of request)

FROM: _____ TO: _____

Fees:
First request in a 12-month period – FREE
Subsequent requests – available upon 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.

_____ _____
Signature of member or legal representative Date

FOR THP USE ONLY:
Date received:_____Date sent: _____
Extension requested: ☐ No ☐ Yes, Reason: _____
Patient notified in writing on this date: _____
Copy of verification of identity of patient and/or legal representative obtained/filed:

Staff member processing request: _____