

**REQUEST FOR AN ACCOUNTING OF DISCLOSURES**

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| **CLIENT INFORMATION** |
| NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Last First MI* |
| ALIAS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ | DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ |

I would like an accounting of how my protected health information was disclosed by Greater New Beginnings, as required by federal regulations. I understand that Greater New Beginnings does not have to tell me about the following types of disclosures:

1. Disclosure for purposes of treatment, payment and health care operations or as part of a limited data set.
2. Disclosures to me or disclosures authorized by me.
3. If the Health Care Agency uses a facility directory, disclosures for use in a facility directory.
4. Disclosures to persons involved in my care.
5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).
6. For national security or intelligence purposes.
7. To correctional institutions or law enforcement officials.
8. Disclosures made prior to April 14, 2003.
9. Disclosures incident to a use or disclosure otherwise permitted or required by federal law.

NOTE: There may be a time when specific disclosure cannot be reported. This would occur when a health oversight agency or law enforcement official has notified Greater New Beginnings that an accounting of disclosures to the agency or official about the individual must be suspended. The health oversight agency or law enforcement official must provide a statement to Greater New Beginnings that such a disclosure would be reasonably likely to impeded the activities of the agency or the official and specify a time period for the suspension. Greater New Beginnings shall limit the temporary suspension to no longer than thirty (30) days from the date of the statement unless the health care oversight agency or law enforcement official has stated otherwise.

**I want an accounting of the following disclosures that cover the following time period (be**

**specific)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(NOTE: The time period must be no longer than six (6) years and may not include dates before April 14, 2003.)*

I understand that the Greater New Beginnings must give me the accounting of disclosures within 60 days, or tell me that it needs an extra 30 days (or less) to prepare it.

I am entitled to one free accounting of disclosures in any 12 month period. Additional accountings within that 12 month period will cost 10 cents per page plus postage.

Please select an option below:

€ Please send my accounting to the address provided at the bottom of this form.

€ I want to pick up the accounting. Please call me at the phone number at the bottom of this form when it is ready.

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website. The Privacy Notice is available at all Greater New Beginnings facilities. You may also contact the Administrative Office at 714-617-4886.

If you believe your privacy rights have been violated, you may file a complaint with Greater New Beginnings, the County, or with the Secretary of the Department of Health and Human Services. To file a complaint with Greater New Beginnings, contact the Administrative Office at 510-663-9092. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**TODAY’S DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP (choose one):**

€ Client € Parent € Guardian € Representative € Conservator

€ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMPLETE ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address City State Zip Code

**TELEPHONE #:** ( ) -