Accounting of Disclosures Request

Name:_____ DOB / ID #: _____

Mailing Address: _____Phone#: _____

Date of Request: _____/_____/_____

I hereby request an accounting of disclosures made of my health information by the Lincoln-Lancaster County Health Department for the following time frame (Please note the maximum time frame that can be requested is six years prior to the date of request):

From: _____ To: _____

I understand this accounting will not reflect any of the following:

- disclosures made to carry out treatment, payment or health care operations
- disclosures authorized in writing by me or my legal representative
- disclosures made to me or to my legal guardian
- disclosures made for facility directory
- disclosures made to assist in notifying a family member, personal representative, or another person responsible for my care of my location, general condition or death
- disclosures made for national security or intelligence purposes
- disclosures made to assist in disaster relief
- disclosures made to correctional institutions or law enforcement regarding inmates

I understand there is no fee for the first accounting request in a 12-month period. For subsequent requests in the same 12-month period, I will be charged a reasonable fee which I agree to pay.

I understand this accounting will be provided to me within sixty (60) days of this request unless I am notified in writing that an extension of up to thirty (30) days is needed.

_____ _____

Signature of the Patient or Legal Representative Date

DEPARTMENT USE ONLY:

Date received:_____ Date Accounting Sent:_____ Extension Requested: NO YES

Comments: _____

_____

Staff Signature: _____Date: _____/_____/_____

_____Copy Sent to City Privacy Officer Date: ____/__/____

CITY OF LINCOLN NEBRASKA