Patient Name:

DOB:

MRN:

Menlo Medical Clinic
1300 Crane Street * Menlo Park, CA 94025

HIPAA Request for Accounting of Disclosures

I would like to request an accounting of how my Protected Health Information (PHI) was disclosed by Menlo Medical Clinic as required by federal regulations. I understand that Menlo Medical Clinic does not have to tell me about the following types of disclosures:

1. Disclosures made prior to April 14, 2003.
2. Disclosures for purposes of treatment, payment, and health care operations.
3. Disclosures to me or disclosures authorized by me.
4. Disclosures to persons involved in my care.
5. Disclosures for notification purposes (to notify a family member, personal representatives or other person of my location, general condition, or death.)
6. Disclosures for national security or intelligence purposes.
7. Disclosures to correctional institutions or law enforcement officials.

I also understand that the government, under limited circumstances, may suspend my right to an accounting of some of all disclosures.

I want an accounting of disclosures that covers the following period:

From: _____ Through: _____
(Note: The time period must be no longer than six years and may not include dates before April 14, 2003).

I want an accounting of disclosures in the following form:

☐ Mail to (Complete Mailing Address): _____
_____

☐ I prefer to pick-up the accounting. Please call me at the following phone number when it is ready to be picked up: (Phone Number) _____

I understand that Menlo Medical Clinic must provide the accounting of disclosures within 60 days of my request or notify me that an extension of an extra 30 days (or less) is required to prepare it.

I am entitled to one free accounting of disclosures in any 12-month period. A fee of $15.00 will be charged for every additional request in a 12-month period.

_____ _____
Signature: Patient/Parent/Personal Representative Date

If other than patient, state relationship: _____

If interpreted: _____ _____ _____
Interpreter's Signature **Print Name** **Language**

_____ _____ _____
Date **Time** **Position/Relationship to Patient**

Send completed request form to: Menlo Medical Clinic, Chief Privacy Officer, 1300 Crane Street, Menlo Park, CA 94025 or fax to 650-324-9447.