



Request for Accounting of Disclosures

Date of Request: _____

Patient/Individual

First Name

Middle Initial

Last Name

Date of Birth

Phone Number (with area code)

Email Address (optional)

Requestor (if different from Patient/Individual)

Written permission/documentation must be on file for a party to make a request on the patient's behalf.

First Name

Last Name

Relationship to Patient

Phone Number

Email Address (optional)

Disclosure Time Period

I am requesting a list of disclosures made relating to my health information for the following time period:

Start date: _____ End date: _____

Review and Sign

This request will be reviewed and may or may not be granted. You will receive a response within 60 days after Colorado Physician Partners receives your request.

I am requesting Colorado Physician Partners provide a list of disclosures relating to my protected health information. I understand that:

- The list is free one time in any 12-month period. A fee may be charged for additional lists in the same 12-month period.
- The following disclosures will not be included:
 - Disclosures made more than six years before this request
 - Disclosures relating to treatment, payment or health care operations will be listed
 - Disclosures that have been authorized to the patient
 - Disclosures to the patient or personal representative
 - Disclosures for national security or intelligence purposes
 - Disclosures made to law enforcement officials or correctional facilities for purposes related to inmates or individuals in lawful custody
 - Disclosures made incident to otherwise permitted or required uses or disclosures

I acknowledge that I have read all of the above information.

Signature of Individual or Individual's Legally Authorized Representative

Date

X _____

Please send this completed form by mail or email to:

Attn: Privacy Officer

Physician Health Partners

PO Box 13406

Denver, CO 80202-9998

Privacy@Alpine-Physicians.com