ASAS HEALTH

Request for Accounting of Disclosures

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 ASAS receives your request.

I am requesting ASAS Health 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