KINGS VIEW

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date: _____ Client Name: _____

Date of Birth: _____ Medical Record #: _____

I. REQUEST

I would like an accounting of how my protected health information was disclosed by Kings View as required by federal regulations.

I understand that Kings View does **not** have to tell me about the following types of disclosures:

1. Disclosures for purposes of treatment, payment and health care operations.
2. Disclosed as part of a limited data set.
3. Disclosures to me or authorized by me.
4. For national security or intelligence purposes.
5. To correctional institutions or law enforcement officials that have custody of a client.
6. Disclosures made prior to April 14, 2003.
7. Disclosures incidental to a use or disclosure otherwise permitted or required by federal law.

I also understand that my right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

I want an accounting of disclosures that covers the following time period (**Note: Last 6 years only)**

FROM: _____ **TO:** _____

I am interested in the following specific disclosures of my protected health information (**Note: Not required**):

_____

_____

I want the accounting of disclosures in the following form:

_____ On paper

_____ I'll pick up–please call me at the following phone number when it is ready:

_____

_____ I want the accounting mailed to me at the following address:

_____

_____ Electronically

_____ E-mail my accounting to the following email address

(OVER)

I understand that Kings View 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. If this is a second accounting in the last 12 months, the cost is $_____.

Date: _____ Time: _____ AM / PM

Signature: _____
(Client/legal representative)

If signed by someone other than the client, indicate relationship: _____

Print name: _____
(Legal representative)

RETURN this form to the Kings View facility where you receive(d) services.

For more information about your privacy rights-

- See the *Notice of Privacy Practices* available on our website at www.kingsview.org OR
- Obtain a copy of the *Notice of Privacy Practices* at the facility where you receive(d) services.

If you believe your privacy rights have been violated, you may file a complaint. *You will not be penalized for filing a complaint.*

To file a complaint with Kings View, call or write the Privacy Officer. All complaints must be submitted in writing to:

Kings View
Attention: Privacy Officer
7170 N. Financial Drive, Suite 110
Fresno, CA 93720
Phone (559) 256-1080

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
Office of Civil Rights
90 7th Street, Suite 4 – 100
San Francisco, CA 94103
Phone (800) 368-1019
TDD (800) 537-7697

Medical Record #: _____
Date of Birth: _____
MO/DA/YR
Date of Request: _____
MO/DA/YR

II. RESPONSE

We received your request for an accounting of disclosures dated

_____ Your accounting of disclosures of protected health information is enclosed.

_____ We need more time to process your request. We will send your accounting of disclosures by *(date)* _____

_____ You did not provide all the information we needed on your form. Please complete highlighted areas on your form and return it to us.

_____ You have already received one free accounting of disclosures within the last 12 months.

Additional accountings cost $ _____ Please arrange with arrange with Medical Records to pay this fee.

_____ Other _____

By: _____ _____
Print Name *Title*

_____ _____
Signature *Date*

(✓) Enclosures:
____ Accounting of Disclosures of Protected Health Information
____ Request form needing correction and return envelope

III. CLIENT NOTIFICATION

Date: _____ Method: ____ Mail ____ Telephone ____ In Person

Notified By: _____ _____
Print Name *Title*

_____ _____
Signature *Date*