CenterWell
Senior Primary Care

6350 West Colonial Drive
Orlando, FL 32818
PH: 866-222-0403

Request For Accounting Disclosures of Protected Health Information

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

By signing below, I am requesting an accounting disclosure of health information for the following period: From: ______/______/______ To: ______/______/______
Start Date **End Date**

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive or release my accounting disclosures, including the following:

____
Name of Clinic

I understand that this accounting for disclosures will include disclosures made only to those organizations or persons other than:

♦ Those occurring prior to April 14, 2003.	♦ For national security or intelligence purpose**.**
♦ To myself or persons involved in my care.	♦ Pursuant to my authorization.
♦ To correctional institutions or law enforcement officials under certain circumstances.	♦ Those exceeding a period of six years prior to the date of this request.
♦ Those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out your operation.	

I understand that my request for an accounting of disclosures will be processed within 60 days of submitting this form. I will be notified of the need for an extension of not more than 30 days to process the request, the reasons for the delay and the date when I can expect to receive the requested accounting.

Please send this accounting by:

☐ Paper copy ☐ Call at number above to pick up ☐ Mail to address above

☐ CD (must call for password)

☐ *Email: ______________________________

*All emails are routinely sent encrypted, however, I understand that records sent through email poses a security risk and that is my requested method of receipt. (Please Initial) ______________

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Print Name ______________________ Date ______________________

Signature ______________________

*Name of Interpreter/Translator (if required) ______________________ Phone Number ______________________

***If a translator or interpreter was required.**

OFFICE USE ONLY

Notice of Decision

Request is: ☐ Approved/Completed

☐ Denied

Reason for denial:

☐ Disclosures occurred prior to April 14, 2003.

☐ Disclosure exceeds more than a six-year period.

☐ No disclosures made for reasons other than those permitted as listed above.

Facility Name ______________________

Office Personnel (Print Name) ______________________ Date Request was Processed ______________________

Office Personnel Signature ______________________