



Saint Luke's Health System
Accounting of Disclosure Request

To obtain information on where protected health information was disclosed outside of treatment, payment purposes, healthcare operations or when authorized, please complete the below information. This form is not for use if request information on who accessed a record.

Name of Facility Providing Care: _____

Patient Name: _____ Birth Date: _____

Address: _____

Phone Number: () - Medical Record Number: _____

Date Range of Accounting: From: _____ To: _____

**Please note that the Accounting period is only required/maintained for six (6) years prior to date of request.*

Signature of Patient: _____ Date/Time: _____
(or Legal Representative)

Relationship to Patient if signed by Representative: _____

*Please Return To: Entity Privacy Site Coordinator or HIM Dept. or
SLHS Privacy Office, 901 E. 104th St., Mailstop 900N, Kansas City, MO 64131*

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FOR ORGANIZATIONAL USE ONLY (To be completed by Privacy Site Coordinator)

Request Received By: _____ Title: _____ Date: _____

Request Assigned To: _____ Title: _____ Date: _____

Date Accounting Due to Patient: _____ **30-Day Extension Due Date:** _____

Date **Receipt of Accounting** Request letter sent to patient: _____

An Accounting will be returned to the patient 60 days from the date received. We are allowed a 30-day extension.

If a **30-day extension** was requested, enter date of letter sent: _____

Fee Payment Received: _____ **Payment Reminder Sent:** _____
(Date) (Date)

Date **Accounting Report mailed** to patient: _____

\$ _____ **Accounting of Disclosure Fee** (First request within a 12-month period has no charge)
(See policy for charges if more frequent. Log the Accounting in PPro.)

Notes: _____

Privacy Site Coordinator to File in Medical Record

Patient Label: