

DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

45 CFR 164.528; 45 CFR 5b.9(c)

Date of Request: _____

Patient Name: _____

Health Record No: _____ Date of Birth: _____

Patient Address: _____

Address to send accounting (if different from above and accounting is to be mailed):

I would like an accounting of disclosures for the following time frame:

From: _____ To: _____

If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/entity, please describe the disclosures for which you are seeking an accounting:

I understand that the accounting will be provided to me within 60 days of the date of this request, unless IHS extends the time frame for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive the accounting.

Signature of Patient or Authorized
Representative (or witness if patient is
unable to sign)

Date

For IHS Use Only:

Date Received: _____ **Date Sent:** _____

Name/Title of IHS employee processing request: _____