OWYHEE COMMUNITY HEALTH FACILITY
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Date of Request: The information is to be disclosed by:

Patient Name		Name of Facility
Health Record Number	Date of Birth	Address
Address		City/State/Zip code
City/State/Zip code		Phone/Fax Number

I would like an accounting of disclosures for the following time frame (e.g., From: 01/01/09 To: 01/30/09).

From:_____ To:_____

If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/organization, 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 OCHF 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 PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

FOR OCHF USE ONLY

DATE RECEIVED	DATE SENT
NAME/TITLE OF OCHF EMPLOYEE PROCESSING REQUEST	