Hill Physicians

Request for an Accounting of Disclosures

Health Insurance Portability and Accountability Act of 1996
45 CFR 160 §164.528

Please fill in

Individual's First and Last Name ___________________________

Hill Physicians MR Number: ___________________________

I request that Hill Physicians Medical Group provide to me an Accounting of all disclosures of my PHI as required under the HIPAA regulations.

Accounting period (not to exceed 6 years): ______________ to ______________

Limitations of accounting:

☐ All disclosures ☐ Only disclosures to ___________________________

☐ Other (please describe): ___________________________

The contents of the accounting shall be in a form of Hill Physicians' choosing and shall contain a minimum of the following information:

1. The date of each, if any, disclosure;
2. The name of the entity or person who received each disclosure of PHI and, if known, the address of such entity or person;
3. A brief description of the PHI disclosed; and
4. A brief statement regarding the purpose of the disclosure.

I understand that the following list of disclosures is excluded from the accounting requirements and any information regarding such disclosures, if any, will not be included in the accounting:

1. To carry out treatment, payment or healthcare operations;
2. Information about me that is shared with me;
3. That are Incidental;
4. In facility directories;
5. Involving or notifying family members or other individuals involved in my care or payment for that care;
6. Of a limited date set;
7. Made with my authorization;
8. For national security or intelligence purposes;
9. To correctional institutions of for law enforcement officials having lawful custody of me; and
10. That occurred more than six years prior to the date of this request.

—Form continued on back

Hill Physicians

Please fill in

I understand that I have the right to:

1. Receive the accounting within sixty (60) days of Hill Physicians' receipt of the request or no later than ninety (90) days of the date of receipt if Hill Physicians requests an extension in writing;
2. To receive one (1) accounting free in any twelve (12) month period. PriMed and/or Hill Physicians may charge a reasonable cost-based fee for additional requests from me within the same 12-month period, provided that PriMed and/or Hill Physicians advises me in advance of the fee and provides me with an opportunity to withdraw or modify the request in order to reduce or avoid a fee.

Dated ____________________ By: ____
Signature

____
Print your name

I am the authorized representative of ____________________________________.

I am submitting this request for an Accounting for and on behalf of the above Individual

for the following reason: ____

____

Dated ____________________ By: ____
Signature

____
Print your name

____
Your Title

Please return this form to Hill Physicians by mail or fax:

Mail

Hill Physicians Medical Group
Attn: Director, Customer Service
P.O. Box 5080
San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Director, Customer Service

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