ALASKA NATIVE MEDICAL CENTER
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name	Date of Birth	Patient Record Number
Patient Address	City, State, Zip	Telephone # Alternate #

I would like an accounting of disclosures for the following time frame (not to exceed six years prior to the date of this request or begin prior to April 1, 2003):

From: _____ To: _____

I am seeking an accounting of only a certain type(s) of disclosure, or disclosures, to a specific person/entity: ❑ Yes ❑ No

If yes, please describe:

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

I have read and understand that as provided by federal law this accounting of disclosures excludes the following disclosures:

1. To carry out treatment, payment, and health care operations.
2. To the patient or the patient's legal guardian/representative pursuant to the right to access the patient's health information.
3. That constitute incidental disclosures occurring as a by-product of a use or disclosure otherwise permitted or required by law as long as appropriate.
4. Pursuant to an authorization.
5. For the facility's directory or to persons involved in the patient's care or other notification purposes.
6. For national security or intelligence purposes as prescribed by law.
7. To correctional institutions or law enforcement officials for individuals in the custody of such institution or official.
8. As part of a limited data set.
9. That occurred prior to April 14, 2003.

Additionally, there may be situations where ANMC must temporarily suspend the right to an accounting.

Signed: _____ Patient or Patient's Legal Guardian/Representative Authority: _____ (If signed by Patient's Legal Guardian/Representative)	Date: _____

For Organization Use Only:

❑ Request Accepted	❑ Request Suspended
Date and Time Request Received:	Date and Time Accounting Suspended:
Name and Title of Staff Member Processing Request:	
Verification Method:	