Health Care Component: _____

Unit Privacy Officer: _____

Request for Accounting of Disclosures of Patient Protected Health Information

Instructions: Please print then sign the form.

Patient Name, Date of Birth and SSN: _____ _____/_____/_____ _____	Missouri State Health Care Component _____
Patient Address: Street number, Street name, City, State, Zip Code _____ _____	
Please specify the time period for which you are requesting the accounting of disclosures: _____	
This is the first request for an accounting of disclosures: Yes No IF NO, I agree to pay costs associated with this request for an accounting of disclosures: Yes No (The first request in a 12 month rolling period is free of charge. Charges accrue for more than one request within that 12 month period.)	
Please indicate the patient, parent of a minor, or any legal guardian or personal representative who is requesting the accounting of disclosures	
Individual's Name: _____	Relationship to Patient: _____
_____ Signature of Patient or Legal Representative	_____/_____/_____ Date
Missouri State USE ONLY	
Date Received:	Accounting has been: ☐GRANTED
Copy provided to patient on _____ (date) Letter written to patient on _____ (date)	
Name and Title of Staff Member processing request: Date the Accounting of Disclosures Provided:	
Signature of Unit Privacy Officer	Date