



CHILDREN'S MEDICAL CENTER
 1935 Medical District Drive • Dallas, Texas 75235
 7601 Preston Road • Plano, Texas 75024
 Dallas (214) 456-7000 Legacy (469) 303-7000

Medical record number: _____

Patient: _____

Date of birth: _____

ROIF
 CMC52706-001NS Rev. 04/2009

**Request for an Accounting of
 Disclosures of
 Health Information**

I request an accounting of disclosures for the above named patient. I understand that there may be a fee for this accounting. I am aware that the maximum time frame that can be requested is six (6) years prior to the date of the request. The accounting will be provided within sixty (60) days from the receipt of the request unless I am notified in writing that an extension of up to thirty (30) days is needed.

TIME FRAME FOR ACCOUNTING OF DISCLOSURES

I request an accounting of all disclosures for this time period: **From** _____ **To** _____

Please send the accounting of disclosures to the name and address below.

 Name Phone number

 Address (street, city, state, zip code)

Date: _____ **Signature:** _____
Patient or legally authorized representative

 Printed name of patient or legally authorized representative

 Relationship to patient

TO BE COMPLETED BY PERSON PROCESSING REQUEST

Date received: _____ Received by: _____ Dept: _____

Fee for first request in a rolling 12-month period: No charge Fee for subsequent requests: _____

Date accounting sent: _____ Date extension requested: _____

Reason for extension: _____