Hillsborough County Florida

**Patient Request for Accounting**

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**Hillsborough County Patient Request for Accounting of Disclosures of Protected Health Information**

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

***Right to Request an Accounting of Disclosures of PHI and Our Duties:***

Hillsborough County is committed to protecting your personal health information under the HIPAA Privacy and Security Rules 45 C.F.R. §§ 164.103, 164.105.

You (or your authorized representative) have the right to receive an accounting of certain disclosures of your PHI made within six (6) years immediately preceding your request. But, we are not required to provide you with an accounting of disclosures of your PHI: (a) for purposes of treatment, payment, or healthcare operations; (b) for disclosures that you expressly authorized; (c) disclosures made to you, your family or friends, or (d) disclosures made for law enforcement or certain other governmental purposes.

***Request for an Accounting of Disclosures of PHI:***

Below, please specify the period of time for which you are requesting an accounting of disclosures of your PHI. If you do not specify a time period, Hillsborough County _____ Department will provide an accounting of disclosures during the previous six (6) years that we were required to track.

*Period of time for which I am requesting an accounting:* _____

***Signature of Requestor:*** _____ ***Request Date:*** _____

***Requestor Information (if requestor is different from patient):***

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____