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PRACTICE IN CLINICAL CHILD, CONSULTING AND FORENSIC PSYCHOLOGY

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**PATIENT/CUSTODIAN REQUEST FOR
ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION**

The federal Health Insurance Portability and Accounting Act (HIPAA), effective 14 April, 2003, entitles you to receive a record of all persons, agencies and organizations who may have had access to your confidential health information through this office. By completing and returning this form to the address above, you are formally requesting a full accounting of any and all such releases from this office.

For more information about your rights under HIPAA go to <http://www.cms.gov/hipaa/> write to Centers for Medicare & Medicaid Services 7500 Security Boulevard, Baltimore MD 21244-1850 or call toll-free: 877-267-2323

I, _____, request an accounting for
(Please print your full first and last name)

disclosures of protected health information (please check one):

- in my own name
- in the name of a minor child for whom I am presently legal guardian

for the period beginning:

_____ through _____
(Month/Day/Year) (Month/Day/Year)

I understand that this accounting for disclosures will not include:

- Disclosures to any entity regarding my treatment, payment, or health care operations
- Disclosure to me or my personal representative
- Disclosures that I authorized by completing an authorization form
- Disclosures Incident to a use or disclosure otherwise permitted or required by law
- Disclosures for national security or intelligence purposes (see *Notice of Privacy Practices*)
- Disclosures to correctional institutions or law enforcement officials under certain circumstances

You may receive the first accounting for disclosures within a 12-month period at no charge. If you are requesting a subsequent accounting within a 12-month period of another request, you will be required to pay the charge of twenty-five dollars (\$ 25.00) for this accounting.

You may receive an accounting of disclosures for a period of up to 6 years from the date of this request for disclosures that occurred after April 14, 2003.

I will respond to your request for the accounting of disclosures within a 60 day period of the receipt of your request. This period may be extended for another 30 days if I choose to provide you with a written statement of the reasons for the delay and the date by which you will receive the accounting. There are also certain circumstances where your right to receive an accounting for disclosures of your health information may be temporarily suspended.

Please specify the mailing address this accounting should be delivered to:

Name _____	
Address _____	
City _____	State _____ Zip _____
_____ Patient/recipient Signature	_____ Date

Please print your name in full

Please sign your name

Please print the PATIENT's name in full if you
are not the patient

Please print your relationship to the patient if
you are not the patient

Please print today's date

Please print the PATIENT's date of birth