REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient or patient's authorized representative complete 1. - 4.

1. PATIENT INFORMATION

Date of Birth: ____________________

Patient Name: ____

Address: ____

____

Address to send disclosure of accouting information (if different from above):

____

____

Name of Person Requesting Accounting: ____

Relationship to Patient: ____

2. DATES REQUESTED

I would like an accouting of disclosures for the following timeframe:

From: ____________________ To: ____________________

Please note: the maximum timeframe that can be requested is six years prior to the date of your request and after April 13, 2003.

3. FEES

I understand there is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is $5.00. I understand I will be notified if the fee applies to my request.

4. RESPONSE TIME

I understand that the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Signature of Patient or Patient's Authorized Representative:

____ Date: ____________________

5. THIS SECTION FOR WAKEMED USE ONLY

Date request received: ____________________

Disclosures for time period requested? No __________ Yes __________

Date notification or accounting mailed: ____________________

Fee applicable to this request? No __________ Yes __________

Date patient informed of need for payment of fee: ____________________

Date fee received: ____________________

Extension requested? No __________ Yes __________

If yes, reason for extension: ____

Date patient notified in writing of extension ______________________________

Name of person who updated disclosure log __________ ____________________

Date disclosure log updated: ____________________

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