



Use this form to request an accounting of disclosures of your protected health information (PHI) that we maintain.

Please complete the following:

NAME		DAYTIME PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	CONTRACT NUMBER		

Please read and complete the following:

You have the right to an accounting of disclosures we, or our business associates, have made of your PHI in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment and health care operations activities; as part of a limited data set; incidental to an allowable disclosure; for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody.

Please specify the date range for the accounting of disclosures you are requesting:

From _____ to _____

You are entitled to one free disclosure accounting every 12 months, upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

Please sign and date:

I request an accounting of all disclosures as specified above. I understand that I am entitled to one free disclosure accounting every 12 months. I agree to pay a reasonable fee for additional accountings, if I have already received one within the previous 12 months.

Signature: _____ Date: _____

*If you are not the patient, please sign and write today's date below, then check the box that describes your relationship to the patient. If you are not the parent of the patient, please attach proof of your relationship to the patient. **NOTE: An authorization is required if you are not the personal representative.***

Print Name of Personal Representative: _____

Signature of Personal Representative: _____ Date: _____

Parent Legal Guardian Power of Attorney Executor Other _____

Please return this form to the Family Health Center where you receive your care:

Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917	Family Health Center – Lake Lansing 1525 W. Lake Lansing Road East Lansing, MI 48823	Former patients of Fashion Square, Essexville, and Midland Family Health Centers return forms to: Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917
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