Request for Accounting of Disclosures

Tepeyac Family Center LLC. dba, Tepeyac OB/GYN
4001 Fair Ridge Dr. Suite 304, Fairfax, VA 22033
Phone: 703-273-9440 ● Fax: 703-273-9445
www.tepeyacobgyn.com ● tfc.portalforpatients.com

INSTRUCTIONS: *Complete your portion of the form, sign it and date it. Attach verification of identity (e.g., copy of driver license or insurance card with photograph) and, if applicable, verification of authority (e.g., authorization form, power of attorney). Send the form and attachments to us at the above address to the attention Tepeyac Privacy Officer. The accounting will be provided within 60 days unless there is an unforeseen delay, in which case we will notify you in writing that an extension is needed, not to exceed 30 days*.

Patient Name:_____ Account Number: _____

Date of Birth:_____ Phone Number:_____

Email Address:_____ Address to which response should be sent::_____
_____

Verification of Identity: _____

If person making the request is not the patient, also complete the following:

Name of Requestor: _____

Relationship to Patient or Legal Authority:_____

Verification of Identity: _____

Verification of Authority:_____

Phone Number:_____

Please provide an accounting of all disclosures of my/the patient's health information not related to treatment, payment, or healthcare operations, or not authorized by the patient or the patient's legal representative, during the following dates from **_____/_____/_____ to _____/_____/_____** .

FEES -- please choose one Option and initial both spaces

Option A: This is my first accounting request in the current 12 month period _____
and I understand there is no fee for this request, but a fee will be charged if I request another accounting within the next 12 months _____

Option B: I have already requested one or more accountings within the past 12 months_____
and I understand the fee for this request is $35 in advance and I wish to proceed _____

_____ _____
Signature of Patient or Legal Representative Date

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FOR OFFICE USE ONLY:

Date request received:_____ Extension Needed: ____Yes ____No

If yes, give reason:_____

Patient notified of extension in writing:

(Date)_____by (Name)_____

Date of Payment for Accounting, if Applicable_____ Cash Check Credit Debit

Date accounting sent:_____

Person who completed accounting:_____

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