Request for Accounting of Disclosures

Tepeyac OB/GYN
4001 Fair Ridge Dr., Suite 304, Fairfax, VA 22033
Phone: 703-273-9440 ● Fax: 703-273-9445
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INSTRUCTIONS: *Complete your portion of this form. Attach verification of identity (e.g., copy of driver license) and, if applicable, verification of authority (e.g., authorization form, power of attorney). Send the form and attachments to us at the above address. 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:_____

Date of Birth:_____ Phone Number:_____ Verification of Identity:_____

Email Address:_____

Address:_____

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

Name of Requestor: _____ Phone Number:_____

Relationship to Patient or Legal Authority:_____

Verification of Identity: _____Verification of Authority:_____

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 _____

FOR OFFICE USE ONLY:

Date request received:_____ Extension: Y/N If yes, give reason:_____

Patient notified of extension: (Date)_____ by (Name)_____

Payment Date:_____ Cash Check Credit A mount:_____ Date accounting sent:_____