



REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Date: _____

Please type or print the patient's information:

_____	_____	_____	_____	_____	
Last Name	First	MI	Date of Birth	Medical Record Number	
_____			_____	_____	
Street Address			City	State	Zip Code

I would like an accounting of how my protected health information has been disclosed by Department of Health Services (DHS). I understand that DHS does not have to tell me about the following types of disclosures:

- Disclosures for purposes of treatment, payment and health care operations
- Disclosures to me
- Disclosures for use in the hospital's directory
- Disclosures to persons involved in my care
- For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death)
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- Disclosures made prior to April 14, 2003
- Disclosures made pursuant to an authorization
- Incidental disclosures that occur as a by-product of a permitted disclosure
- Disclosure of a limited data set for research, public health or health care operations purposes

I also understand that the government under limited circumstances may suspend my right to an accounting of disclosures.

I want an accounting of disclosures that covers the following time period:

_____ to _____
(Note: The time period must be no longer than six years and may not include dates before April 14, 2003.)

I want the accounting of disclosures in the following form:

- On paper
 - Electronically
 - Please send my accounting to the following address or provide an e-mail address if you are requesting to receive the information electronically
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- I want to pick up the accounting of disclosures. Please call me at the following phone number when it is ready: (_____) _____
- Please mail the accounting of disclosures to me at the

I understand that DHS must give me the accounting of disclosures within 60 days of receiving request or tell me that it needs an extra 30 days (or less) to prepare it. I am entitled to one free accounting of disclosures in any 12-month period. Reasonable fees will be charged for additional lists within the 12-month period. I understand that I have the right to take back or change my request by writing to DHS in order to avoid or lower the charges.

For more information about your health privacy rights, ask the facility representative for a copy of our **Health Agency Notice of Privacy Practices**. You may also obtain a copy by visiting our website at www.dhs.lacounty.gov

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

Facility Stamp Here

Los Angeles County Department of Health Services
DHS Privacy Officer
313 N. Figueroa Street, Room 703
Los Angeles, CA 90012
800-711-5366

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your health care need.