PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Please forward this form to the Release of Information (ROI) Department at Swedish Medical Center.

You may forward the request to the following address:

Swedish Medical Center
Attn: Release of Information
747 Broadway
Seattle, WA 98122

Fax: (206) 320-7194
Email: HIMAffiliateAccess@swedish.org

PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name: _____ Date of Birth: _____

I request that Swedish provide me with an accounting of the disclosures of my protected health information made by Swedish for the following time period:

_____ to _____ (No more than six years prior to the date of request)

Please provide me with the accounting via the following (check one):

☐ Fax: _____ ☐ Email: _____

☐ Paper - Address: _____

I understand that Swedish is not required to tell me about disclosures made:

- To carry out treatment, payment and health care operations
- To me or authorized by me
- For use in the hospital's directory
- To persons involved in my care or for other notification purposes (such as for my location, general condition, or death)
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials with lawful custody of me
- As part of a limited data set
- More than six years prior to the date of the request

I understand that my right to an accounting of some or all disclosures may be suspended by law enforcement or government officials under limited circumstances.

I understand that I am entitled to an accounting free of charge every 12 months, and that I may be charged if I request any additional accountings within the same 12 months. I understand that I will be notified of the cost involved and will have the opportunity at that time to withdraw or modify my request before any costs are incurred.

SIGNATURE: _____ DATE: _____

(If signed by a personal representative of the patient, please complete the following.)

Personal representative's name: _____

Relationship to patient: ☐ Parent ☐ Other: _____

☐ Legal guardian* ☐ Power of Attorney for Healthcare*

* Attach legal documentation if you are the legal guardian or Power of Attorney for Healthcare

If you believe your privacy rights have been violated, you may file a complaint with this facility or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

To be completed by Swedish.

Date Received: _____ Received by: _____ Department: _____

☐ Response deadline has been extended. Disclosure must be completed by the following date: _____

(no later than 90 days after date request was received).

☐ Disclosure was provided free of charge on _____

☐ Disclosure will cost $ _____ and the patient was notified of this cost on _____

☐ The patient agreed to pay the cost and the Accounting was provided on _____

☐ The patient refused to pay the cost and no Accounting was provided.