Authorization
REQUEST FOR ACCOUNTING DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Identify Spectrum Health Facility ______________________________

PATIENT INFORMATION

Patient name ______________________________ Date of birth ______________

Address ______________________________ Phone ______________

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I am requesting an accounting of disclosures of my protected health information. I cannot request disclosures for dates more than six years before the date of this request. I am requesting disclosures made between ______________ - ______________ (date range). I understand the facility has 60 days to comply with my request. This time period may be extended by an additional 30 days if I am provided with the reasons for the delay within the initial 60 day time period.

The accounting I receive <u>will not contain</u> disclosures:

- To carry out treatment, payment, or healthcare operations
- Pursuant to my authorization
- Made to me
- For the facility's directory
- To persons involved in my care or other notification purposes
- Incidental to permissible use or disclosure
- For national security or intelligence purposes
- To correctional institutions or in custody law enforcement officials
- As part of a limited data set
- De identified data

______________________________ ______________________________

Time Date Patient Signature **TIME** **DATE** Witness to Signature

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I, ______________________________, hereby certify that I am the ______________ of the patient; that patient is unable to consent because patient is a minor, or because:

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______________________________ ______________________________

Time Date Signature of Parent, Legal Guardian, Patient Advocate or Next of Kin **TIME** **DATE** Witness to Signature

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

OVER ➔

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

© Spectrum Health

☐ A copy of my personal representative form or legal document is on file

☐ Attached is a copy of my personal representative form or legal document

Keep a copy of this request for your records

SPECTRUM HEALTH STAFF

Send this completed request form to Spectrum Health's Health Information Management Department for review and approval/denial.

If Spectrum Health Medical Group, send to Health Information Management (HIM) manager below.

For questions, call HIM manager at 616.485.3718

- Mail code: 063
- Fax: 616.391.1521
- Mail: Spectrum Health Medical Group, HIM manager,
  100 Michigan Street NE, Grand Rapids, MI 49503

If Spectrum Health Hospital Group, send to Health Information Management (HIM) supervisor below.

For questions, call HIM supervisor at 616.391.0035

- Mail code: 063
- Fax: 616.391.1521
- Mail: Spectrum Health, HIM supervisor,
  100 Michigan St. NE, Grand Rapids, MI 49503

FOR OFFICE USE ONLY

Date request received ______________________

Request received by (staff name) ______________________

Date disclosure completed ______________________

DATE __________ **TIME** __________ Staff signature ______________________

Printed staff name ______________________

Department ______________________

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