GARNER RHEUMATOLOGY
& INFUSION CENTER

810 Timber Drive, Garner, NC 27529 • Tel 919-747-9040 • Fax 1-866-837-8477
www.garnerrheumatology.com

ACCOUNTING OF DISCLOSURE(S) REQUEST FORM

I,_____, request that Garner Rheumatology and Infusion Center, PLLC ("***Practice***") provide me with an accounting of any and all applicable "non-authorized" uses and disclosures of my protected health information (PHI) between_____(beginning date) and _____(ending date).

I would like to limit this request for accounting to include disclosures only pertaining to:

_____

_____

_____

I understand that I may be charged for this information if I have previously requested this information within the last twelve (12) months. I have been informed of the approximate cost of [$2.00 per page] and agree to be financially responsible for this charge.

Patient Signature:_____ Date:_____ DOB:_____

Patient Printed Name:_____

Privacy Officer Action / Comments (Action Must Be Taken Within 60 Days of Request):	
☐ Request Approved. ☐ Request Denied For the Following Reason. Health Information was released: ☐ For treatment, payment, or health care operations. ☐ To patient. ☐ With patient's authorization. ☐ For national security or disaster response purposes. ☐ For law enforcement purposes. ☐ As part of a limited data set. ☐ Prior to April 14, 2003. ☐ Incident to an otherwise permitted use or disclosure.	
☐ Patient Contacted	
☐ Practice requests a 30-day extension to respond due to:	
Signature of Privacy Officer:	Date: