SECTION A: INDIVIDUAL REQUESTING DISCLOSURE ACCOUNTING

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of Birth: _____/_____/_____

SECTION B: PLEASE READ THE FOLLOWING AND COMPLETE THE INFORMATION REQUESTED

As a patient of MultiCare Health System (MHS) you have the right to an accounting of certain disclosures that MHS has made of your protected health information (PHI) starting with disclosures made on or after April 14, 2003 for up to six (6) years prior to the date of your request. The accounting for disclosures will not include the following:

- Disclosure made to carry out your treatment
- Disclosures made to receive payment for your treatment
- Disclosures made for health care operations
- Information sent to you, your personal representative, family, close friends and others involved in you health care
- Disclosures made for national security or intelligence purposes
- Disclosures made to certain law enforcement agencies
- Disclosures made pursuant to an authorization

You are entitled to a free disclosure accounting once in each 12 month period. If this is not the first disclosure accounting that MHS has made to you in this 12 month period, we will charge you for preparing the accounting.

I request an accounting of the disclosure of my PHI made within the _____ months prior to the date of this request. I understand that the accounting will not include disclosures made before April 14, 2003, or for any excluded disclosures explained above. I understand that I will be charged for this disclosure accounting if I have already received a disclosure accounting from MHS within the last 12 months, and I agree to pay the charge.

Signature: _____ Date: _____

Print Name: _____

If this request is made by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

❑ 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.

Please mail the completed form to:

MultiCare Health System
Medical Records
P.O. Box 5299
Tacoma, WA 98415-0299

Please keep a copy of this request for your records.

Patient Identification - Always Attach Patient Label

Name:

MRN#:

CSN#:

Age/Sex:

Verification of Patient Identification
(Patient Drivers License #)

PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

MultiCare

88-0459-0 (3/09)