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) 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 your 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 any excluded disclosures explained above. I understand that I may be charged. Once submitted, we will send the accounting of the disclosure to you within 60 days with a possible 30-day extension if we notify you in writing.

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
Health Information Services
P.O. Box 5299
MS 1002-1-HIM
Tacoma, WA 98415-0299

Notice of language availability | Free interpreter services:

If you speak a language other than English, MultiCare offers interpreter services at no cost to you. To learn more about this free service, scan the QR code or visit **multicare.org/interpreter.**

Please keep a copy of this request for your records.

Patient Identification - Always Attach Patient Label

Name:

MRN#:

CSN#:

Age, Sex & Gender:

PATIENT REQUEST FOR AN ACCOUNTING OF DISCLOSURES

88-0459-0 (Rev. 6/26)