



0048911

**ALBERT EINSTEIN HEALTHCARE NETWORK  
PATIENT REQUEST FOR ACCOUNTING OF  
DISCLOSURES OF PROTECTED HEALTH INFORMATION**

AEMC    Ctr One    GCHS    MossRehab    Belmont    Willowcrest  
 Other \_\_\_\_\_

Patient Label (Name and Medical Record #)

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
\_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

1. By my signature below, I hereby request an accounting of all accountable disclosures of my Protected Health Information that the Albert Einstein Healthcare Network ("the Network") has made during the past number of years checked below (**please check one box**):

- 1 Year                       2 Years                       3 Years                       4 Years
- 5 Years                       6 Years                       Other (please specify) \_\_\_\_\_

- 2. I understand that the Network is not obligated to provide me with an accounting of any reportable disclosures made before April 14, 2003.
- 3. If I need further information regarding the types of disclosures that are "reportable" I understand that I can ask for a copy of the Network's Notice of Privacy Practices and obtain a list of the types of disclosures that are "reportable."
- 4. I understand that disclosures made in connection with treatment, payment and health care operations conducted by the Network are not "reportable" and that any disclosures made by the Network pursuant to my authorization are also not "reportable."
- 5. I understand that if this is my first request during the past twelve (12) months for an accounting of disclosures, then I will receive my requested accounting free of charge.
- 6. I understand that if I have made more than one request during the past twelve (12) months for an accounting of disclosures, then the Network will charge me per page for copying costs in compliance with Pennsylvania Law and **\$15.00 per hour** of clerical work necessary to complete my requested accounting.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Guardian/Legal Representative:** \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_