Attachment B
PR.PHI 145.08

Carolinas HealthCare System
Request for Accounting of Non-Authorized Disclosures of Patient Information

I hereby request the accounting of non-authorized disclosures of my patient information.

Patient Name: _____
First **Middle/Maiden** **Last** **Suffix**

Current Mailing Address: _____
Street Address

_____
City State Zip Code

Home Telephone # _____ **Work Telephone #** _____

Social Security # _____ **Date of Birth** _____

Dates of Service Requested: **From** _____ **To** _____

You may request a listing of disclosures for any segment of the most recent 6 years dating from April 14, 2003.
There will be a charge of at least $25 per request after the first request within a 12 month period.

Facility Where Services Rendered: _____

Printed Name (Patient/Authorized Representative*)	**Signature**	**Date**	**Time**

* If Authorized Representative, please indicate relationship to patient: ☐ Spouse ☐ Parent ☐ Other: _____

FOR CAROLINAS HEALTHCARE SYSTEM USE ONLY

☐ Identification verified ☐ Processing fee received ☐ Copy of request given to patient

CHS Employee: _____
Signature Title Date

Unit # / Chart ID # _____

☐ Request Accepted ☐ Accounting Mailed ☐ Partial Request Accepted Date:

☐ Request Denied ☐ Denial Notice Mailed ☐ Partial Request Denied Date: _____

Explanation of Denial: _____

CHS Employee: _____
Signature Title Date