Accounting of Disclosures Request

I. Date:_____ **SSN:**_____ **OR** **Medicaid ID #**_____

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Date of Birth:**_____

II. I receive(d) services from the Department at the following location:

☐ District Office *Location*_____
☐ New Hampshire Hospital
☐ Glencliff Home for the Elderly
☐ Other location *Please specify*_____

III. I am requesting an accounting of disclosures of the following information:

☐ Medical Records ☐ Billing Records ☐ Other

Please specify the information you wish to receive an accounting of:

_____

IV. I am requesting an accounting of disclosures for the following time period:
The maximum time frame that can be requested is six years prior to the date of request, but not before April 14, 2003.

From:_____ To:_____

V. Please sign below.

Fees: **First request in a 12-month period**: Free
Additional requests in a 12-month period: First 25 pages free, $.25 per additional page.

I understand that there may be a fee for this accounting and wish to proceed.

_____ _____
Print Name Signature

_____ _____
Date Notary Name & Seal

If the above signature is that of a patient representative, please attach the appropriate legal documentation.

For Department Use Only

Date received:_____ Date sent:_____

1. If applicable, the Department has verified the identity of the patient representative.

2. Extension required ☐ Yes ☐ No Reason_____

_____ _____
Signature /Title Date