CEDARS-SINAI MEDICAL CENTER®

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION

Date:_____

Patient Name:_____

Date of Birth:_____

I would like an accounting of how my protected health information was disclosed by Cedars Sinai Medical Center, as required by federal regulations. I understand that the Medical Center does not have to tell me about the following types of disclosures:

1. Disclosures for purposes of treatment, payment and health care operations or as part of a limited data set.

2. Disclosures to me or disclosures authorized by me.

3. Disclosures for use in the hospital's directory.

4. Disclosures to persons involved in my care.

5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).

6. For national security or intelligence purposes.

7. To correctional institutions or law enforcement officials.

8. Disclosures made prior to April 14, 2003.

9. Disclosures incident to a use or disclosures otherwise permitted or required by federal law.

I understand that my right to an accounting, or some or all disclosures, may be suspended by the government under limited circumstances.

I want an accounting of disclosures that covers the following time period:

_____

(Note: the time period must be no longer than six years and may not include dates before April 14, 2003.)

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I want the accounting of disclosures in the following form:

❑ On paper

❑ Electronically

❑ Please send my accounting to the following address (provide an e-mail address if you requested your accounting electronically)

_____

❑ I want to pick up the accounting. Please call at the following phone number when it is ready:_____

I understand that the Medical Center must give me the accounting of disclosures within 60 days, or informs me an additional 30 days (or less) is required to process my request.

I am entitled to one free accounting of disclosures in any 12 month period. Additional accountings will cost $_____ each. I understand I have the right to withdraw or modify my request by writing to the Medical Center in order to avoid or reduce the fee.

_____

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at **www.csmc.edu** or contact the Privacy Manager at (310) 423-6666 or send a written request to: Privacy Manager, 8700 Beverly Boulevard, Los Angeles, CA 90048.

If you believe your privacy rights have been violated, you may file a complaint with the Medical Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Medical Center, contact the Cedars Sinai Medical Center Privacy Manager at (310) 423-6666. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

_____
Signature of patient or patient's representative

_____
If representative, give relationship