Elevate Physical Therapy Fitness and Performance

REQUEST FOR ACCOUNTING OF DISCLOSURES OF MEDICAL RECORDS

DATE OF REQUEST ____________________

PATIENT NAME ____________________

DATE OF BIRTH ____________________

PERMANENT ADDRESS ____________________

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PHONE NUMBER ____________________

NAME OF REQUESTER ____________________

PURPOSE OF REQUEST ____________________

REQUESTED FORMAT ☐ **USB DRIVE** ☐ **PRINTED**

DISTRIBUTION METHOD ☐ **PICK UP @ CLINIC** ☐ **MAILED** ☐ **FAXED**

MAILING ADDRESS OR FAX #
FOR DISCLOSURES
(if different from above) ____________________

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DATES REQUESTED
I would like an accounting of all disclosures for the following time frame. (Please note, the maximum time frame that can be requested is six years prior to the date of your request or February 1, 2020, whichever is earlier).

FROM: ____________________ **TO:** ____________________

FEE
I understand there is a fee for this accounting and wish to proceed. I also understand that the accounting will be provided to me within 30 days unless I am notified in writing that an extension of up to 30 days is needed.

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Signature of Patient or Legal Representative Date

The fee for this request will be based upon current ORS 192.563 guidelines. The minimum charge for my request will be $30.00. The cost will increase based upon the number of pages for printed medical records. Records will be sent upon receipt of the fee and signed request form.

FOR OFFICE USE ONLY

Date Received: ____________ **Date Accounting Sent:** ____________

Extension requested: ☐ **Yes or** ☐ **No** **Notice Sent:** ____________

Person Processing Request: ____________________