## REQUEST FOR AN ACCOUNTING OF DISCLOSURES

## King County Behavioral Health and Recovery Division

## The Chinook Building,

## 401 Fifth Avenue, Suite 400

## Seattle, WA 98104

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|  |  |  |
| Client Name: |  |  |
| Previous Name: |  |  |
| Date of Birth: |  |  |
|  |  |  |

I would like an accounting of disclosures for the following time frame. I understand that the maximum time frame that can be requested is six years prior to the present date.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| From: |  |  | To: |  |

|  |  |
| --- | --- |
| Address to which the accounting should be sent: |  |
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|  |
|  |

I understand that the accounting will not contain disclosures that were made to carry out treatment, payment, or healthcare operations; disclosures to myself; disclosures to which I consented; and certain other disclosures that may be omitted according to law, as defined in the King County Behavioral Health Organization Policies and Procedures.

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| --- |
| Fee (circle the correct fee for this request and enclose with request): |
| First request in a 12-month period: | Free |
| Subsequent requests: |  |  |

I understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client or legal representative Date

(Completed form may be given to site Health Insurance Portability and Accountability Act (HIPAA) officer or mailed to the HIPAA Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

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| **FOR INTERNAL USE ONLY**Identity of client verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If signed by a legal representative, authority verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Sent: (must be within 60 days, if no extension requested) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Extension Requested: \_\_\_\_ No \_\_\_\_ Yes (give reason): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client notified in writing on this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff person processing request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |