

**The Children's Hospital of Philadelphia**

Request for an Accounting of Disclosure(s) of Medical Information

I, \_\_\_\_\_, request an accounting of disclosures of medical information of \_\_\_\_\_, excluding disclosures that are authorized, or disclosures made for treatment, payment, or healthcare operations.

**(PLEASE PRINT)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Please list the time period for which you would like an accounting (THIS TIME PERIOD MAY NOT BE MORE THAN SIX YEARS AND CANNOT INCLUDE DATES PRIOR TO APRIL 14, 2003):

\_\_\_\_\_

You will receive a response to your request in writing within sixty (60) days.

If The Children's Hospital of Philadelphia is unable to give you with an accounting within sixty (60) days of your request, you will receive a statement within those sixty (60) days informing you when you will be given the accounting. In any case, the accounting will be provided to you within no more than ninety (90) days of the receipt by The Children's Hospital of Philadelphia of your original request.

The Children's Hospital of Philadelphia may temporarily hold a patient's right to receive an accounting of disclosures of her/his medical information as outlined in the Notice of Privacy Practices to a health oversight agency or law enforcement agency if the accounting would be reasonably likely to make the agency's activities more difficult.

DATE: \_\_\_\_\_

Signature of patient/parent/legal guardian: \_\_\_\_\_

Received by: \_\_\_\_\_

Title: \_\_\_\_\_

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(TO BE COMPLETED BY CHILDREN'S HOSPITAL STAFF)

PATIENT MR#: \_\_\_\_\_

**The Children's Hospital of Philadelphia**  
**Health Information Management Department**  
**34th and Civic Center Boulevard**  
**Philadelphia, PA 19104**  
**[http://www.chop.edu/about\\_chop/hipaa/npp.shtml](http://www.chop.edu/about_chop/hipaa/npp.shtml)**