



OE10007

Patient Name \_\_\_\_\_  
MRN \_\_\_\_\_  
Acct Number \_\_\_\_\_

- Backus Hospital
- Charlotte Hungerford Hospital
- Hartford Hospital
- Manchester Memorial Hospital
- MidState Medical Center
- St. Vincent's Medical Center
- The Hospital of Central CT
- Windham Hospital
- Hartford Healthcare Medical Group

**Patient Request for an Accounting of Disclosures**

The Health Insurance Portability and Accountability Act ("HIPAA") gives you the right to receive an accounting of certain disclosures of your health information that are made by Hartford Healthcare and its Business Associates for up to six (6) years prior to the date of your request. You are not entitled to receive an accounting of disclosures that are made to carry out treatment, to obtain or make payment for treatment, or for health care operations. You are not entitled to receive an accounting of disclosures that are made to you or pursuant to your authorization, to your family or other persons involved in your care, for national security, or certain law enforcement purposes. You are entitled to one free accounting every 12 months. If you already requested an accounting within the last 12 months, we would charge you a reasonable, cost-based fee to cover the costs of producing an additional accounting. You will be notified of any fee in advance. You will receive the accounting based on your preferred delivery method within 60 days of receipt of your request and will be notified if an additional 30 days (or less) is needed to prepare it.

To request an accounting of disclosures, please complete the form below and send to: **Release of Information, 9 Farm Springs Road, Farmington, CT 06032 or [HHCROI@hhchealth.org](mailto:HHCROI@hhchealth.org)**

**Patient Name** (please print): \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**I request an accounting of disclosures of my health information that were made during the following time frame: from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_.**

**I understand that I may be charged a reasonable, cost-based fee if I have already received an accounting within the last 12 months and I agree to pay the fee.**

**I want the accounting of disclosures in the following form:**

- On paper sent to my address
- Electronically – may not be available
- I will pick up the accounting of disclosures

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**(Patient or person authorized to sign)**

*If the person consenting is not the patient, please print name and type of authority to sign. Supporting documents should be provided at the time of submission.*

**Name/Authority:** \_\_\_\_\_