STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

By completing and submitting this form, I am requesting an accounting of disclosures of my Protected Health Information (PHI).

I understand that such accounting will be limited to disclosures that were not for the purposes of treatment, payment, or health plan operations (or other exceptions under 45 CFR § 164.528(a)(1) of the HIPAA Privacy Rule) and for which I have not provided a written authorization. The accounting will only include disclosures of PHI made by the Missouri Department of Health and Senior Services (DHSS) in the six (6) years prior to the date of this request.

VERIFICATION (type or print) - please complete the following for verification

NAME OF INDIVIDUAL	SOCIAL SECURITY NUMBER	DATE OF BIRTH

PHONE NUMBER (WITH AREA CODE)	ADDRESS

CITY/STATE/ZIP CODE

NAME AND ADDRESS TO SEND ACCOUNTING OF DISCLOSURES (IF DIFFERENT THAN ABOVE)

NAME	ADDRESS

CITY/STATE/ZIP CODE

If this request is made by someone other than individual, state relationship and authority to make request

Individual is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney of Healthcare ☐ Authorized Legal Representative

DATE RANGE REQUESTED

I would like an accounting of all disclosures for the following timeframe. **NOTE:** The *maximum timeframe* that can be requested is *six years prior to the date of your request.*

FROM	TO

I AM REQUESTING INFORMATION ABOUT DISCLOSURES OF THE FOLLOWING TYPE OF INFORMATION:

FEES

- One accounting per twelve (12)-month period is provided without charge; DHSS may impose a fee for any additional accounting.
- I understand if the information on this form is incomplete the form will be returned to me and the request will not be considered until the form is complete.

SIGNATURE — I have read and understand the above information

SIGNATURE	DATE

FOR DHSS USE ONLY: TO BE COMPLETED BY THE DHSS PRIVACY OFFICER

CONTACT PERSON	DATE RECEIVED
REVIEWED BY	REVIEW DATE
SIGNATURE	DATE

RETURN FORM TO: DHSS PRIVACY OFFICER, P.O. BOX 570, JEFFERSON CITY, MO 65102