

**Jewish Hospital &  
St. Mary's HealthCare**

**JEWISH HOSPITAL & ST. MARY'S HEALTHCARE, INC.  
ACCOUNTING OF DISCLOSURES OF  
PROTECTED HEALTH INFORMATION REQUEST FORM**

Patient Name: \_\_\_\_\_

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

Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_ Account #: \_\_\_\_\_

Under the provision of the Health Insurance Portability and Accountability Act, 1996 (HIPAA), Public Law 104-191, and the Standards of Privacy of Individually Identifiable Health Information, I would like to request an Accounting of Disclosures of my protected health information by the following Jewish Hospital & St. Mary's HealthCare, Inc. (JHSMH) entities (please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Jewish Hospital                      | <input type="checkbox"/> VNA Nazareth Home Care                       |
| <input type="checkbox"/> Jewish Hospital Medical Center East  | <input type="checkbox"/> Jewish Hospital Health Center - Meade County |
| <input type="checkbox"/> Jewish Hospital Medical Center South | <input type="checkbox"/> Sts. Mary & Elizabeth Hospital               |
| <input type="checkbox"/> Jewish Hospital Shelbyville          | <input type="checkbox"/> Our Lady of Peace                            |
| <input type="checkbox"/> Frazier Rehab Institute              | <input type="checkbox"/> JHSMH Physician Practice                     |
| <input type="checkbox"/> Frazier Rehab Outpatient             | <input type="checkbox"/> Other: _____                                 |

for the following time period \_\_\_\_\_ to \_\_\_\_\_. I understand the accounting will not include disclosures for the following purposes where a valid authorization was obtained; to carry out treatment, payment and health care operations; to individuals of protected health information about them; for directory purposes, individuals involved in your care or other notification purposes; for national security or intelligence; to correctional institutions or law enforcement; or as part of a limited data set. I understand that I may not request information relating to disclosures made prior to April 14, 2003, per Privacy Regulations. I also understand that I am entitled to one free disclosure in a 12-month period and additional disclosures are subject to a fee charged by the JHSMH facility.

**Signature of Patient or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**JHSMH Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

You have the right to request a list of the disclosures JHSMH made of your health information for purposes other than treatment, payment or health care operations as described in the JHSMH Notice of Privacy Practices. It excludes disclosures JHSMH may have made to you, requested by you or that you authorized, as well as for a facility directory, to family members or friends involved in your care, or for notification purposes. JHSMH must act on your request for an accounting, no later than 60 days after receipt of such a request. You have the right to receive specific information regarding these disclosures made up to six (6) years before your request (not including disclosures made before April 14, 2003). You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

