SAINT JOSEPH MERCY HEALTH SYSTEM
A MEMBER OF TRINITY HEALTH

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION

Patient Name: (Last)________________________________(First)__________________(M.I.)________

Address:
(Street/Box)_____________________________(City)__________________(State)_______(Zip)_________

Telephone: (day) (_____)_______________(eve) (_____)______________

Medical Record #: _________________________ (Optional) Date Of Birth _____________

Time period of disclosures for which you are requesting an accounting (the list we provide will include disclosures made within the last six years (data available beginning April 14, 2003), unless you specify a shorter period):
From __________________ to ____________________

Information about your rights to receive an accounting
You have the right to get a list of instances in which we have disclosed your health information. We are not required to list disclosures made:

- for treatment, payment and health care operations;
- directly to you or
- to your family or friends who are part of your care or paying for your care;
- through our facility directory;
- for disaster relief purposes;
- for national security purposes;
- to law enforcement personnel; or
- before April 14, 2003.

We will respond to your request for an accounting no later than 60 days after receipt of such a request. If we are unable to provide the accounting within the time required, we may extend the time to provide the accounting by no more than 30 days. In the event of a time extension, we will provide a written statement of the reason(s) for the delay and the date by which we will provide the accounting. We may only have one such extension of time for action on a request of an accounting.

Charges for Accounting
The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the same 12-month period. You have the right to withdraw or modify your request by writing to us in order to avoid or reduce the fee.

Where to Submit this Form
You must submit this completed form to Saint Joseph Mercy Health System, Health Information Services, 5301 East Huron River Dr., PO Box 995, Ann Arbor, MI 48106-0995.

By submitting this form, I hereby request the Organization to provide me with an accounting of disclosures of my health information made by the Organization.

____ ______________________________
Signature of Patient or Representative Date

______________________________ ______________________________
Date form received Date Accounting Sent