3712 MacArthur Blvd. Ste 208
New Orleans, LA 70114
(504) 362 - 8020
info@nolaacupuncture.com
www.nolaacupuncture.com

ACUPUNCTURE WELLNESS CENTER

5150 Highway 22, Suite A6
Mandeville, LA 70471
(985) 635 - 8846
info@mandevilleacupuncture.com
www.mandevilleacupuncture.com

Request for Accounting of Disclosures of Health Information

Client Identification:

Client Name:_____ Date of Birth:_____ Client ID #:_____

Client Address:_____

Street Apt # City State Zip

Home Phone:(_____)_____ Work Phone : (_____)_____ Cell Phone : (_____)_____

You have the right to an accounting of certain disclosures that Acupuncture Wellness Center, LLC has made of your protected health information starting with disclosures made on or after April 14, 2003 for up to six (6) years prior to the date of your request. You are not entitled to receive an accounting for disclosures that Acupuncture Wellness Center, LLC made to: carry out your treatment, obtain, or make payment for treatment, for our health care operations. Acupuncture Wellness Center, LLC does not have to account for disclosures made to you, or to your personal representative, your family, close friends and others involved in your health care, or for disclosures made for national security or intelligence purposes, or to certain law enforcement agencies, or for disclosures made pursuant to an authorization.

You are entitled to a free disclosure accounting once in each 12-month period. If this is not the first disclosure accounting that Acupuncture Wellness Center, LLC has made to you in this 12-month period, we will charge you for preparing the accounting.

Request for Accounting:

I hereby request an accounting of the disclosures of my protected health information from Acupuncture Wellness Center, LLC designated record set(s) that was made from _____ to _____ (not to exceed a six (6) year period of time). I understand that the accounting will not include disclosures made before April 14, 2003, or for any disallowed purpose as explained above. I understand that I am entitled to a free disclosure accounting once in each 12-month period. I understand that I will be charged for this disclosure accounting if I have already received a disclosure accounting from my health plan within the last 12 months, and I agree to pay the charge.

I further understand this accounting shall not include the following disclosures:

- To me/my personal representative/other persons involved in my care;
- To carry out treatment, payment, and health care operations;
- Disclosures requiring authorization;
- Facility Directory;
- Disclosures for national security or intelligence purposes;
- To correctional institutions or law enforcement about a person in their custody.

_____ _____ _____

Name (Printed) Signature Date

If this request is made by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

❑ A copy of my personal representative form or legal document is on file.

❑ Attached is a copy of my personal representative form or legal document.

This section is for agency use only

❑ **Request APPROVED**

Agency Requirment: ❑ Provide Client with copy of Accounting of Disclosure form

❑ **Request DENIED**

Reason for Denial: ❑ No disclosures recorded

❑ **Request WITHDRAWN**

By: _____ _____ _____

Staff Signature Title Date