REQUEST FOR ACCOUNTING OF DISCLOSURES

Name of Patient					
Name of Patient	Middle	e	Last	Maiden	
Date of Birth	ate of Birth		Social Security Number XXX-XX-		
	t can be requested is six ye	ears prior to the da	ate of the request, but not I	fee for this accounting. I am aware before 4/14/03. The accounting will on of up to 30 days is needed.	
TIME FRAME FOR ACCOUNTIN	IG OF DISCLOSURES:				
I would like an accounting of all d	isclosures for this time per	iod: From	То	·	
Please send the accounting of dis	sclosures to the name and	address below.			
Name	Phone Number		e Number		
Address (Street, City, State, Zip Code)					
Date:	Signatu	ire:			
	- C	Pa	atient or Legally Authorized Repr	esentative	
		Printed Na	Printed Name of Patient or Legally Authorized Representative		
		Relationship to Patient			
	TO BE COMPLETED B	Y PERSON PRO	CESSING REQUEST:		
Date received:	Received by:		Dent:		
MRN:		Accour	bopt nt #:		
Fee for first request in a 12-month period: <u>No Charge</u> Date accounting sent:		Date exter	nsion requested:		
Reason for extension:					
Resources	h REQUEST	FOR ACCOUNTING (02/2020)	OF DISCLOSURES	Patient Identification	
 Texas Health Arlington Memorial Hosp Texas Health Harris Methodist Hospita 	I Alliance T I Azle T I Cleburne T I Fort Worth T I Hurst-Euless-Bedford T I Southwest Fort Worth T I Stephenville T	Texas Health Presbyterian H Texas Health Specialty Hosp Texas Health Wellness & Re Texas Health Physician Grou Dther	lospital Dallas lospital Denton lospital Kaufman lospital Plano lital Fort Worth covery Center (Mansfield)		