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LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

DEPARTMENT OF MENTAL HEALTH

Patients' Rights Office
510 S Vermont Ave, 21st Floor
Los Angeles, CA 90020

LETTER RESPONDING TO CLIENT'S REQUEST FOR ACCOUNTING OF DISCLOSURES

{Mr./Ms./Mrs. Client's Name}
{Client's Address}
{City, State Zip Code}

Date of Birth: {Date}
MIS #: _____

{Date of Letter}

Dear {Mr./Ms./Mrs. Client's Name}:

Thank you for submitting your **Request for Accounting of Disclosures**. We received your written request, stamped on _____ for an accounting of disclosures of your protected health information. We have determined that:

☐ We need additional time to process your request. We will send you an accounting of disclosures by _____.

☐ We have attached a copy of your Request for an Accounting of Disclosures Form with the areas marked that need further information for your request to be processed. Please complete the enclosed Form and return it to us for reconsideration.

☐ You have already received one free accounting of disclosures within the last 12 months. An additional accounting will cost $ _____ . Please send a check for this amount, made payable to {Insert Name of Facility} , or bring it to the {Insert Name of Facility} at {Insert Facility Address}

Please include this Response to Request for Accounting of Disclosures Form with your check.

☐ Other:

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Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Program / Unit Manager
Department of Mental Health
Los Angeles County