Clear entire form

REQUEST FOR ACCOUNTING OF DISCLOSURES

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client | Date of Birth | MIS #

Street Address | City, State, Zip

Address or FAX Number where you want the accounting sent

Name | FAX Number (include area code)

Street Address | Phone Number (include area code)

City, State, Zip

NOTICE TO CLIENT: Your request for an accounting of disclosures of your protected health information **only** is applicable to the information maintained by the DMH. If you would like to request an accounting of disclosures of your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

REQUEST FOR ACCOUNTING OF DISCLOSURES:
I request an accounting of disclosures of the protected health information in my designated record set from to (not to exceed 6 years) maintained or created by the following providers associated with the DMH:

Name of Physician or Other Provider	Facility/Clinic

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I understand that the first accounting in a twelve (12) months period is free of charge, but that I can be charged a reasonable fee for any additional accountings.

I understand that that the accounting must include all disclosures, **except** for disclosures:

1. to carry out treatment, payment and health care operations;
2. to individuals of protected health information about them;
3. incident to a use or disclosure permitted by the Privacy Regulations;
4. pursuant to the individual's authorization;
5. to persons involved in the individual's care or for a facility directory;
6. for national security or intelligence purposes;
7. to correctional institutions or law enforcement officials to provide them with information about a person in their custody;
8. as part of a limited data set; or
9. that occurred prior to the compliance date.

Signature of Client / Personal Representative Date

If signed by other than the client, state relationship and authority to do so: