DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Date: _____

Please type or print the patient's information:

_____ _____

Last Name First MI Date of Birth Medical Record Number

_____ _____

Street Address City State Zip Code

Under the Health Insurance Portability and Accountability Act (HIPAA), a patient, or his/her personal representative has the right to request an accounting of disclosures of Protected Health Information (PHI) contained in the medical and billing records.

I would like an accounting of how my protected health information has been disclosed by Department of Health Services (DHS). I understand that DHS does not have to tell me about the following types of disclosures:

- Disclosures for purposes of treatment, payment and health care operations
- Disclosures to me
- Disclosures for use in the hospital's directory
- Disclosures to persons involved in my care
- For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition,or death)
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- Disclosures made prior to April 14, 2003
- Disclosures made pursuant to a valid authorization
- Incidental disclosures that occur as a by-product of a permitted disclosure
- Disclosure of a limited data set for research, public health, or health care operations purposes

I also understand that the government under limited circumstances may suspend my right to an accounting of disclosures.

I want an accounting of disclosures that covers the following time period:

_____ to _____

(Note: The time period must be no longer than six years and may not include dates before April 14, 2003.)

I want the accounting of disclosures in the following form:

☐ Electronically: Email address:

☐ I want to pick up the accounting of disclosures. Please call me at the following phone number when it is ready: (_____) _____

☐ Please mail the accounting of disclosures to me at the following address:

I understand that DHS must give me the accounting of disclosures within 60 days of receiving request or tell me that it needs an extra 30 days (or less) to prepare it. I am entitled to one free accounting of disclosures in any 12-month period. Reasonable fees will be charged for additional lists within the 12-month period. I understand that I have the right to take back or change my request by writing to DHS in order to avoid or lower the charges.

For more information about your health privacy rights, ask the facility representative for a copy of our ***Health Agency Notice of Privacy Practices***. You may also obtain a copy by visiting our website at www.dhs.lacounty.gov

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. You will not be penalized or retaliated against for filing a complaint**.** To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

Signature of patient or patient's representative _____ Date _____

Select the DHS Facility for which this request applies:

☐ Los Angeles General Medical Center

☐ Olive View-UCLA Medical Center

☐ Harbor-UCLA Medical Center

☐ CHC/Health Center:

☐ Other:

☐ Rancho Los Amigos National Rehabilitation Center

☐ High Desert Regional Health Center

☐ Martin Luther King, Jr. Outpatient Center

Facility Name Street Address City State Zip Code

Los Angeles County Department of Health Services
DHS Privacy Officer
313 N. Figueroa Street, Room 703
Los Angeles, CA 90012
800-711-5366

Request processed by _____ Date_____

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your health care needs.