APPALACHIAN STATE UNIVERSITY
COMMUNICATION DISORDERS CLINIC

REQUEST FOR ACCOUNTING OF DISCLOSURES

Name:
Address:
Date of Birth:
Phone:

I request an accounting of disclosures of my protected health information made by the Appalachian State University Communication Disorders Clinic to include disclosures made between the dates of _____. I understand that the Clinic has 60 days to comply with this request.

The accounting I receive will NOT contain disclosures:

- To carry out treatment, payment, or healthcare operations
- That occurred prior to the compliance date of April 14, 2003
- Made to me
- To persons involved in my care or other notification purposes
- Incidental to a permissible use or disclosure
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- As a part of a limited data set
- De-identified data

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____

Client, Parent, or Legal Guardian Date

APPALACHIAN STATE UNIVERSITY
COMMUNICATION DISORDERS CLINIC

ACCOUNTING OF DISCLOSURES OF PHI

Requesting Individual _____

This accounting covers disclosures made by the Appalachian State University Communication Disorders Clinic between the dates of _____
and _____.

Date of Disclosure	Entity/Person receiving disclosure	Description of PHI Disclosed	Purpose of Disclosure	Address of Entity/Person Receiving Disclosure