

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
<input type="text"/>	<input type="text"/>

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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.
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Signature of Client / Personal Representative

Date

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