Tuscola County Health Department (TCHD)
Request Form for Accounting of Disclosures of Personal Health Information

Name of Individual:____

Social Security #: ____

Birth date: ____

Address: ____

I hereby request an Accounting of Disclosures of my Protected Health Information for the following time period:

Beginning date: ______________________________

End date: ______________________________

I understand that the Tuscola County Health Department is only required to provide me with an accounting of disclosures that occurred up to six years prior to the date of this request unless the record is an electronic health record. In that event, depending upon the date of the request, no accounting may be required, and even if there is an accounting requirement, it does not have to extend prior to 3 years before the date of that request. I also understand that, as permitted by law, this accounting may not contain disclosures for treatment, payment or health care operations, disclosures made pursuant to a valid authorization, or other disclosures which are not required to be disclosed.

Date of this request: ________________________________

Signature of Individual or Personal Representative: ________________________________

Relationship to Individual: ____

For Tuscola County Health Department Use Only:

Date Received:____________________________

Date report provided:____

Beginning date of accounting:____

Name of Staff Member:____________________________________ Title:_________________

Signature of Staff Member:________________________________ Date:_________________