BERKS COUNTY

REQUEST FOR ACCOUNTING OF DISCLOSURES

1. **Client Name:** _____
2. **Date of Birth:** _____
3. **Request Date:** _____
4. **Address to Receive Accounting:** _____
   _____

I understand that I have the right to an accounting of uses and disclosures of my protected health information for purposes other than treatment, payment and health care operations. I understand that Berks County's responsibility for such accounting became effective April 14, 2003 and that accounting for disclosures prior to that date is not available. I understand that Berks County will maintain the record of any disclosure for six years. I understand that Berks County will respond to this request in fewer than 60 days unless I receive notification in writing that it will take longer to fulfill my request. I also understand that a fee may be charged for more than one accounting in a 12-month period, but Berks County will notify me in advance of such fee.

Please specify the period of time for which you would like an accounting of disclosures of your protected health information. (No accounting is available prior to April 14, 2003.):

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