CVH-531
New 4/03

CONNECTICUT VALLEY HOSPITAL
HEALTH INFORMATION MANAGEMENT
P.O. Box 351 – Middletown, CT 06457

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

I am requesting an accounting of Disclosure of my Protected Health Information.

Name:_____

Other Names Used (if applicable): _____

Date of Birth:_____ Social Security Number: _____

Address:_____

Town _____ State _____ Zip Code _____

Phone Number: _____

Dates of Care: _____

Subject of this Request for Information: _____

_____

_____

_____

Reason for this Request for Information: _____

_____

_____

_____

Please Note: A copy of photo identification with signature must accompany this request. If not available this form must be notarized.

_____ _____

Patient/Conservator Signature Date

HIM Processing:

Date Request Processed: _____
(*Attach Accounting form to original request*)

HIM Staff Initials: _____

ORIGINAL – Medical Record **COPY** – Patient