Northwestern Medicine®

PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name _____

Patient Address_____ City/State/ZIP _____

Date of Birth _____ Phone _____

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. I understand this accounting of disclosures will exclude those about treatment, payment, or healthcare operations, and certain other disclosures (such as any that I requested). **Please note:** The maximum time frame that can be requested is six years prior to the date of your request.

From _____ **To** _____

WHERE WERE YOU TREATED?

Hospital:

☐ Central DuPage Hospital
☐ Delnor Hospital
☐ Huntley Hospital
☐ Kishwaukee Hospital
☐ Lake Forest Hospital
☐ Marianjoy Rehabilitation Hospital
☐ McHenry Hospital
☐ Northwestern Memorial Hospital
☐ Palos Hospital
☐ Valley West Hospital
☐ Woodstock Hospital

Physician Group:

☐ Northwestern Medical Group (NMG) ☐ Regional Medical Group (RMG)

Other:

☐ Behavioral Health: Location(s) _____

☐ Other _____

☐ All NMHC Entities

Please specify area/department(s) from which an accounting of disclosure is needed _____

_____

Send completed request forms to: Email: NMHPrivacy@nm.org. Fax: 312.926.7686.

RESPONSE TIME

I understand that the accounting I have requested will be provided to me within 60 days, unless I am notified in writing that an extension of up to 30 days is needed.

Time _____ Date _____

Signature: Patient or Legally Authorized Patient Representative _____

Relationship to Patient _____