Northwestern Medicine®

Patients' Privacy Rights Coordinator
Email to nmhprivacy@nm.org
Or Fax to 312.926.7686

PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name: _____

Patient Address: _____ City/State/Zip: _____

Date of Birth: _____ Social Security Number____-___-_____ Phone:_____

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. **Please note:** The maximum time frame that can be requested is six years prior to the date of your request.

From: _____ **To:** _____

Treatment Location:

- ☐ Northwestern Memorial Hospital
- ☐ NM Marianjoy Rehabilitation Hospital
- ☐ NM Lake Forest Hospital
- ☐ NM Lake Forest Hospital – Grayslake
- ☐ NM Central DuPage Hospital
- ☐ NM Delnor Hospital
- ☐ NM Valley West Hospital
- ☐ NM Proton Center
- ☐ Northwestern Medical Group
- ☐ KishHealth System Physician Group
- ☐ Marianjoy Medical Group
- ☐ NM Kishwaukee Hospital
- ☐ NM KishHealth Ben Gordon Center
- ☐ NM KishHealth Cancer Center
- ☐ NM Cancer Center - Warrenville
- ☐ NM Cancer Center - Geneva
- ☐ Regional Medical Group

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

_____

FEES

There is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is $20. I understand that there is:

_____ No fee for this _____ A fee for this request in the amount of $20 and I wish to proceed

Send Request To: Manager, Health Information Management, Northwestern Memorial HealthCare, 251 East Huron Street, Feinberg Pavilion/Lower Concourse L340, Chicago, Illinois 60611

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.

_____ _____

Signature: Patient or Legally Authorized Patient Representative Date

_____

Relationship to Patient

FOR INTERNAL USE ONLY
Date Request Received: _____ **Date Accounting Sent:** _____
Extension Requested: _____Yes _____No
If yes, reason: _____
Patient or legal representative notified in writing on this date: _____