Jefferson County Department of Health

Request for Accounting of Disclosures

Patient Information

Last Name	First name	Middle Name	Date of Birth
Address to Send Disclosure List		Telephone Number	
Medical Record Number (if known)		Email Address	

Date of Request:____________________

I understand I have the right to request an accounting of disclosures of my health information made *up to six years* prior to the request date. I understand there are disclosures made for certain purposes that will not be included such as disclosures for treatment, payment, and operations, disclosures I authorized, and other exemptions outlined in the JCDH Notice of Privacy Practices.

I am requesting a list of disclosure made:

Begin Date:____ End Date: ________________________________

I understand there may be a fee for this accounting (if applicable) and wish to proceed. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Fees: First request in twelve-month period: No charge
Subsequent requests: $10.00

____ _________________________________ _______

Patient/Legal Guardian/Patient Representative Signature* Print Name Date

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If guardian/representative, relationship to patient*

*You may be required to submit evidence of guardianship/patient representative.

Mail completed form to:
Release of Information Division
Jefferson County Department of Health (JCDH)
1400 Sixth Avenue South
Birmingham, AL 35233

Or email completed form to: roi.info@jcdh.org

Office Use

Date Received by ROI: _______________ Date Released: ______________

Extension Requested: ☐ No ☐ Yes If yes, reason: ____
If yes, date patient notified:______________________________________

Staff processing request:____Title: __________________________________

Notes: