

Dr. David R. Winchester, D.M.D., P.C.
Request Accounting of Disclosures of Healthcare Information

This form is to request an accounting of all incidences when protected healthcare information which you maintain was disclosed, either by you or by your business associates, during the last six years (but not before April 14, 2003). I understand that use and/or disclosure for purposes of treatment, payment, health-care operations and certain other activities will not be included.

Patient: _____

Please provide this information in the form of

photocopies

other media, _____

specify media requested

Please mail the resulting information to me at this address:

_____ State _____ ZIP _____

Please, contact me when the information is ready and I will arrange to pick it up at your office myself.

Please, contact me when the information is ready. I hereby authorize you to give it to

Mr. Ms. _____

or

Mr. Ms. _____

I understand that you cannot give this information to anyone other than me or the person(s) I have herein authorized to receive it.

I have read your Notice of Privacy Policies and I understand that if I request this information more than one time during a twelve-month period, I may be charged on a reasonable cost-based basis for all expenses incurred in honoring this request for information, including, but not limited to, a per-page copying cost, an hourly cost for staff time required to locate and copy the information, and mailing costs if I request that the information be mailed to me. I also understand that if I request the information on a different medium I will be charged for expenses incurred in honoring my request.

Signature _____ Date _____

If this form is signed by a personal representative of the patient, please, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Mail or deliver the completed form to:

Dr. David R. Winchester
Suite 100
2500 Center Point Parkway
Center Point, AL 35215