Physicians Independent Management Services, Inc.

Request for an Accounting of Disclosures

Patient Name: Date of Birth: Patient Record #

Address

City State Zip Code

I would like an accounting of disclosures for the following time frame.			
From Date:		To Date:	

If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/organization, please describe the disclosures for which you are seeking an accounting:

I understand that the accounting will be provided to me within 60 days of the date of the request, unless the practice extends the time frame for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive the accounting.

Signature of Patient or Personal Representative Date/Time Field

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For Office Use Only

Date Received Date Sent

If denied, reason for denial must be listed.

Comments:

Signature of authorized party reviewing this request:

Date: