



Crossville Medical Group Professional Association

100 Lantana Road, Suite 202, Post Office Box 548, Crossville, TN 38557

(931) 484-5141

www.cmcmd.net



Request for Accounting for Disclosures of Health Information

I, _____ (Print Name), request an accounting for disclosures of my health information for the period:

FROM: _____

TO: _____

I understand that this accounting for disclosures will include disclosures made only to those organizations or persons *other than*:

to those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out your operations

to myself or persons involved in my care

for national security or intelligence purposes (as specified in your Notice of Privacy Practices)

to correctional institutions or law enforcement officials under certain circumstances (as specified in your Notice of Privacy Practices)

that occurred prior to April 14, 2003

____ I understand that I may receive the first accounting for disclosures within a 12-month period at no charge.

____ I understand that I am requesting a second or subsequent accounting in a 12-month period and will pay the charge of \$10.00 for this accounting.

Send this accounting to:

PRINT MAILING ADDRESS:

CITY: _____ STATE: _____ ZIP CODE: _____

X _____ DATE: _____
PATIENT SIGNATURE