**FORM 2516 A**

**MODEL**

**Request for Accounting of Protected Health Information (PHI) Disclosed by**
**North Sound Mental Health Administration**
**117 North 1st Street, Suite 8**
**Mount Vernon, WA 98273**
**(360) 416-7013 toll free (800)-684-3555**

I request an accounting of all of my PHI disclosed by the North Sound Mental Health Administration (NSMHA) pursuant to the requirements of the Privacy Rule. I understand that this accounting will not include disclosures that were:

1. Made to me of PHI about me;
2. Made to carry out my treatment, payment, or health care operations;
3. Made for facility directory purposes and those made to person's involved in my care (relatives and/or friends), as set forth in the "Opportunity to Agree or Object" Policy;
4. Made for notification purposes to my family or personal representatives;
5. For national security or intelligence purposes and disclosure to correctional institutions or law enforcement officials when and if I was an inmate;
6. Incident to a use or disclosure otherwise permitted or required and exempt by law from accounting;
7. Pursuant to my authorization;
8. As a part of a limited data set; and
9. That occurred prior to the compliance date of April 14, 2003.

The period of time I am requesting the accounting for is from:

_____ to _____

I understand that this period of time can be for no longer than 6 years and cannot include any time period before April 14, 2003 (the date the Privacy Rule became effective).

I also understand that the first accounting I request in any 12 month period will be given to me for no charge.

Signed: _____ Date: _____

Print Name Below

_____

For a consumer requesting more than one accounting in a 12-month period, the following additional signature should be obtained:

I understand that because I have requested more than one accounting in a 12-month period, I will be charged a reasonable cost-based fee incurred by NSMHA for completing this accounting. I understand that this cost will be _____ and that payment must be made at the time I receive the accounting or prior to the accounting being mailed to me.

Agreed and accepted: _____ Date: _____

Print Name Below

_____

I elect to (a) withdraw; or (b) modify this request in order to reduce the cost. _____

**PHI Disclosure to be Included in Consumer's Accounting**

Date of disclosure: _____

Name of person and organization receiving disclosure:
_____
_____

Address of person/organization receiving this disclosure:
_____
_____
_____

Description of what information was disclosed:
_____
_____
_____

Brief statement of purpose of disclosure:
_____
_____

Signature of staff person making disclosure: _____

Date of Disclosure: _____

Send completed form to Privacy Officer for entry into Disclosure Accounting database.