REQUEST FOR ACCOUNTING

This FORM is for a patient who wants a list of disclosures of their *Protected Health Information* (an "Accounting".

I wish to receive an Accounting of disclosures of my Protected Health Information, pursuant to Section 164.528 of the HIPAA Privacy Regulation, made by Rite Aid. I understand that:

(1) disclosures made for the purpose of treatment, payment, and health care operations will be excluded;
(2) disclosures made directly to the patient or to patient's family members or friends involved in the patient's care will be excluded;
(3) disclosures made for purposes specifically authorized by the patient will be excluded;
(4) the right to receive an Accounting is subject to certain other exceptions, restrictions, and limitations;
(5) the accounting period may not be longer than six **(6)** years prior to the date of my request.

I am the patient making the request concerning disclosure of my own *Protected Health Information* or I am the patient's personal legal representative as indicated below.

Accounting Period: **From** _____**to**_____.
(Beginning Date) (Ending Date)

(Please Print Clearly)

Name of Patient: _____

Street Address: _____

City: _____ **State:** _____

Zip Code: _____ **Telephone Number:** _____

Date of Birth: _____

If other than patient or parent, proof of authority to sign must accompany this form.

☐ **Patient** ☐ **Parent or Guardian** ☐ **Power of Attorney** ☐ **Court Appointed**

Signature: _____ Date: _____

Print Name: _____

Mail to:

Privacy Office, Rite Aid P.O. Box 3165, Harrisburg, PA 17105.