NH2542

NORTHSIDE HOSPITAL, INC.

AFFIX PATIENT LABEL HERE

English - Spanish - Korean

Name of Hospital or Physician Practice:

_____

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

_____

As a patient, you have the right to receive an accounting of disclosures of your health information that we have made for purposes other than treatment, payment or health care operations. The first accounting you request within a 12-month period will be provided free of charge. For additional accountings during the same 12-month period, you may be charged for the costs of providing the list; however we will notify you of the cost involved and you may choose to withdraw or modify your request.

Please specify the dates to which this accounting request applies: _____ to _____. You may not request an accounting for disclosures made more than six (6) years prior to the date of this request. You understand that under the federal privacy regulations (HIPAA) certain disclosures will not be included in this accounting.

_____ _____

Signature of Patient or Legal Representative Date/Time Reason Patient Unable to Sign

_____

Relationship to Patient If Not the Patient

_____

Interpreter's Signature Date/Time

Note: If remote interpretation used (phone/iPad), record interpreter name, ID#

Interpreter Comments (optional): _____

_____

SUBMIT TO HIS INTERNAL SUPPORT AT HISINTERNALSUPPORT@NORTHSIDE.COM

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

REQUEST FOR ACCOUNTING OF CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION

Reorder #108340 NH2542 **U**
Piedmont Graphics 05/02/2025

Original: Chart