Stony Brook
Eastern Long Island Hospital

Request for an Accounting of Disclosures

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Patient's Address: ____
____
____

Please specify the time period for which you are requesting the accounting of disclosure:
From Date: ______________________________To Date: _________________________________

This is the first request for an accounting of disclosure □ yes □ no

(***The first request in a 12-month period is free of charge. There is a processing fee for more than one request in a 12-month period***)

Printed Name of Individual Completing this Request: ______________________________

Relationship to Patient Named Above: ____

Address of Individual Completing this Request (if other than patient)

____
____
____

Signature of Patient or Legal Representative_______________________________________

(If someone other than the patient is requesting the accounting of disclosure – must be a legal representative as defined in SBELIH Admin. Policy # ERC: 0065 Personal Representative Access to Protected Health Information – parent of an unemancipated minor, legal guardian, appointed healthcare proxy or agent)

This section for SBELIH Use Only

Date Request Received: _______________________________
Accounting has been: □ granted - Copy provided to requester on __________________ (date)
□ not granted - Letter written to requester on ________________ (date)

Printed Name and Title of SBELIH Staff Member Processing Request:
____

Signature of Privacy Officer or Designee ___________________________ Date __________