McLaren
HEALTH CARE

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	
PATIENT ADDRESS:	
TELEPHONE NUMBER:	
DATE OF BIRTH:	**PREVIOUS NAMES DURING REQUESTED TIME PERIOD:**

I, _____, request that McLaren Health Care provide to me an accounting of any disclosures ("Accounting") of my health information.

I am requesting an Accounting of the disclosures made for the time period from:

____/____/____ to ____/____/____ (dates cannot be for more than six (6) years prior to the date of this request).

I understand that McLaren has 30 days to respond to this request, and that if another entity holds the information, or it is offsite, McLaren has 60 days to respond to this request.

Print Name: _____ Date: ____/____/____

Signature: _____

McLaren shall provide one Accounting at no charge during any twelve (12) month period.

Send completed form to:

MCLAREN HEALTH CARE PRIVACY OFFICER
One McLaren Parkway, Grand Blanc, MI 48439; or
Privacy@McLaren.org