McLaren Ambulatory Care Center,
McLaren/Bay Occupational Health and/or Convenient Care Center

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____ / _____ / _____

Patient Address: _____

Social Security #: _____ Telephone #: _____

I, _____ _____, request that McLaren Medical Management, Inc. 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 from the date of this request).

Please send the Accounting to the following address:

_____

_____

I understand that McLaren Medical Management, Inc. shall provide to me one Accounting at no charge during any twelve (12) month period. However, if another Accounting is required within twelve (12) months from the date of this Accounting, McLaren Medical Management, Inc. will charge a $10.00 fee for each subsequent Accounting.

Print Individual's Name: _____ Date: _____ / _____ / _____

Individual's Signature: _____ Date: _____ / _____ / _____

This form may be submitted by mailing to:

McLaren Medical Management, Inc.
401 S. Ballenger Hwy.
Flint, MI 48532
Attn: Privacy Officer

FOR OFFICE USE ONLY

Request Received On:

Date: _____ / _____ / _____

By (Name and Dept.): _____

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name:

Date of Birth: