McLaren Ambulatory Care Center, McLaren/Bay Occupational Health and/or Convenient Care Center REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Please send the Accounting to the following address: I understand that McLaren Medical Group 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 Group will charge a \$10.00 fee for each subsequent Accounting. Print Individual's Name: Date: Date: Date: McLaren Medical Group 401 S. Ballenger Hwy. Flint, MI 48532 Attn: Privacy Officer FOR OFFICE USE ONLY Request Received On:	Patient Name:		Birth Date:	/	/
I am requesting an Accounting of the disclosures made for the time period from: I am requesting an Accounting of the disclosures made for the time period from:	Patient Address:				
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 Group 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 Group will charge a \$10.00 fee for each subsequent Accounting. Print Individual's Name: Date:// Individual's Signature: McLaren Medical Group 401 S. Ballenger Hwy. Filint, MI 48532 Attn: Privacy Officer FOR OFFICE USE ONLY Request Received On: Date:// Date:// Print Individual Received On: Date:// Date:// Privacy Officer	Social Security #:	Telephone #:			
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Date://	FOR OFFICE USE ONLY				
	Request Received On:				
By (Name and Dept.):	Date: / /				
	By (Name and Dept.):				

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name:

Date of Birth: