REQUEST FOR AN ACCOUNTING OF DISCLOSURES

PATIENT INFORMATION Medical Record #: _____

name (print): _____ Date of Birth: _____

Address: _____

City: _____ Daytime phone #: (_____) _____

State: _____ Zip Code: _____ Evening phone #: (_____) _____

Print name and address to send accounting of disclosure, if different from above:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____