REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City/State/Zip Code: _____

Date of Birth: _____ Preferred Telephone: (____) _____ ☐Mobile ☐Home ☐Work ☐Other

Email Address: _____

Delivery Method: ☐ Pickup ☐ Mail ☐ Fax ☐ Secure Email

Disclosure Date-Range Requested: *

From: _____/_____/_____ To _____/_____/_____

Month Day Year Month Day Year

By my signature below, I hereby request an accounting of all accountable disclosures of my/the patient's Protected Health Information that City of Hope's Affiliated Covered Entity (ACE) ("City of Hope")** have made during the date range specified above.

I understand that City of Hope is not obligated to provide me an accounting of any accountable disclosures made more than **6 years before** today's date.

If I need further information regarding the types of disclosures that are "accountable," I understand that I can ask City of Hope for a copy of its policy that describes what types of disclosures are "accountable." In particular, I understand that disclosures made in connection with treatment, payment and certain health care operations conducted by City of Hope are not "accountable," nor are disclosures made by City of Hope pursuant to my authorization.

I understand that if this is my first request during the past twelve (12) months for an accounting of disclosures, then I will receive my requested accounting free of charge. I understand that if I have made more than one request during the past twelve (12) months for an accounting of disclosures, then City of Hope will charge me **$25.00** per request for processing, producing and mailing my requested accounting. If this fee is unacceptable to me I do not need to complete this form, but I understand that if I don't complete this form I will not receive my requested accounting of disclosures.

**City of Hope's Affiliated Covered Entity are healthcare facilities and other healthcare providers that are now or in the future controlled by or under City of Hope's common ownership or control. The City of Hope ACE members are located in California, Arizona, Georgia, and Illinois.
(For a listing of all City of Hope locations and providers, please go to cityofhope.org/locations or call our main number (800) 826-4673.)

PATIENT OR PERSONAL REPRESENTATIVE PRINTED NAME	SIGNATURE	DATE	TIME

If Personal Representative has signed above, please indicate your relationship to the patient:

☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other

City of Hope

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How to Submit Form:
Once completed, please forward to the Health Information Management Service Department using one of the following methods:

COH - California

- Email: himsroi@coh.org
- Fax: (626) 218-8443, Attention: Health Information Management Services (ROI)
- Mail:

  Health Information Management Services (ROI)
  City of Hope
  1500 East Duarte Road
  Duarte, CA 91010

COH - Chicago, Atlanta, Phoenix, Hospitals and Outpatient Care Centers

- Email: himsroi2@coh.org
- Fax: (847) 746-6791, Attention: Health Information Management Services (ROI)
- Mail:

  Health Information Management Services (ROI)
  City of Hope
  2520 Elisha Ave
  Zion, IL 60099