

**Request for Accounting of Health Information Disclosures**

In accordance with my rights as outlined in the Notice of Privacy Practices, I am requesting an accounting of disclosures made by Lighthouse Family Center, Ltd of my health information.

I understand that the first accounting in any 12- month period is free; and I will be charged a fee of $15.00 for each subsequent accounting requested within the same 12-month period.

I further understand that the right to receive this information is subject to certain exceptions, restrictions, and limitations.

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*Client Name (printed) Date of request*

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*Signature of client, parent, or legal guardian*

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\*\*\*\*For office use only\*\*\*\*

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| **Disclosure made to** | **Information Disclosed** |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ○ Diagnostic Assessment ○ Other○ Testing Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Progress Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Individual Service Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○Summary of Treatment Results○ Discharge Summary |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ○ Diagnostic Assessment ○ Other○ Testing Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Progress Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Individual Service Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○Summary of Treatment Results○ Discharge Summary |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ○ Diagnostic Assessment ○ Other○ Testing Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Progress Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Individual Service Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○Summary of Treatment Results○ Discharge Summary |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ○ Diagnostic Assessment ○ Other○ Testing Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Progress Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○ Individual Service Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_○Summary of Treatment Results○ Discharge Summary |

Request # \_\_\_\_\_ in past 12 months $15 Fee Collected ○ Yes ○ No ○ N/A

Prepared by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_