



Request for Accounting of Disclosures Form

Use this form to request that CCH provide you with an accounting of certain disclosures of your Protected Health Information (PHI) made by or on behalf of CCH during a specified time period.

In order for CCH to respond promptly and accurately to your Accounting of Disclosures Request, please complete this form in its entirety.

<u>Individual Last Name</u>			<u>Individual First Name</u>			<u>Individual Middle Name</u>		
Birth Date	Month	Day	Year	Today's Date	Month	Day	Year	
Address			City	State	Zip	Phone		
TIME FRAME FOR ACCOUNTING Please specify the dates between which you would like CCH to account for disclosures of your PHI. NOTE, we are not required to account for disclosures prior to April 14, 2003 or more than 6 years prior to today.			STARTING DATE:					
			ENDING DATE:					
REQUESTED LIMITATIONS ON SCOPE OF ACCOUNTING Please specify if you would like CCH to limit our accounting to certain types of disclosures.								
Signature of Individual				Date				
FOR PERSONAL REPRESENTATIVES OF THE INDIVIDUAL								
Name of Personal Representative				Relationship to Individual				
<i>I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual identified above.</i>								
Signature of Personal Representative				Date				
Please return this form to this address. Or, call this number with questions: 1-877-476-1873				Ashley Huntington, JD, CHC Privacy Officer 1950 W. Polk Street, Suite 9217 Chicago, IL 60612				