
Request for Accounting of Disclosures of Health Information

Mail the request to:

Carolina Complete Health
Privacy Office
10101 David Taylor Drive
Suite 300
Charlotte, NC 28262
1-833-552-3876

or attach as an email to:

CCH_Compliance@Carolinacompletehealth.com

Client Identification

Client Name: _____	Date of Birth: _____	Client ID #: _____			
Client Address: _____	Street	Apt #	City	State	Zip
Client Home Phone #: (____) _____	Client Wk. Phone #: (____) _____				

Request for Accounting

I hereby request an accounting of the disclosures of my health information from this agency's designated record set(s) that was made to persons/agencies outside of this agency from _____ to _____ (not to exceed a six (6) year period of time). I understand that the first accounting within a twelve (12) month period is without charge, but that I can be charged a reasonable fee for any additional accountings within the same time period. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed. I further understand this accounting shall not include the following disclosures:

- To me/my personal representative/other persons involved in my care;
- To carry out treatment, payment, and health care operations;
- Disclosures requiring authorization;
- Facility Directory;
- Disclosures for national security or intelligence purposes;
- To correctional institutions or law enforcement about a person in their custody;
- As part of a limited data set; or
- Disclosures that occurred prior to April 14, 2003.

Signature of Client or Personal Rep

Authority (If Personal Representative)

Date

