REQUEST FOR AN ACCOUNTING OF DISCLOSURES

New River Family Wellness, PLLC
420 East Second Street, West Jefferson, NC 28694

Date of Request: _____ **Medical Record #:** _____
Name: _____ **Date of Birth:** _____
Address: _____
_____
Address to send disclosure accounting (if different than above):
_____
_____

Dates Requested: I would like an accounting of all disclosures for the following time frame. (Please note: the maximum time frame that can be requested is six years prior to the date of the request and does not include any disclosures made prior to April 14, 2003).
From: _____ **To:** _____

Fees:
First request in a 12-month period: Free
For subsequent requests in the same 12-month period: $ _____ (contact office for current rate).

The fee for this request will be: _____
I understand that there is a fee for this accounting and wish to proceed. □ Yes □ No

I 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.

_____ _____
Signature of Patient or Legal Representative **Date**

For New River Family Wellness, PLLC Use Only:

Date Received: _____ **Date Sent:** _____
Extension Requested: _____ **No** _____ **Yes**
Reason: _____
_____
Patient notified in writing on this date: _____
Staff Member Processing Request: _____