REQUEST FOR ACCOUNTING OF DISCLOSURES

You have the right to request an accounting of Protected Health Information disclosed by Erie County. Please refer to the Erie County Notice of Privacy Practices for a more detailed description of your rights. To make a request for an accounting, please complete and return this form to:

Erie County Chief Privacy Officer
95 Franklin Street, Room 1634
Buffalo, NY 14202
Chief.Privacy.Officer@erie.gov

CONTACT INFORMATION

PATIENT NAME: _____
(please print)

PHONE NO.: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

EMAIL: _____ DATE OF REQUEST: _____

DESCRIPTION OF REQUEST

1. Please indicate which of the following department(s) of Erie County you would like to provide an accounting of disclosures:

☐ Department of Emergency Services
☐ Department of Health
☐ Department of Mental Health
☐ Department of Senior Services
☐ Department of Social Services
☐ Youth Services
☐ Other _____

2. Please indicate the period of time for which you are requesting an accounting:

   The period of time I am requesting the accounting is from: _____ to _____ (*the period of time can be for no longer than 6 years, unless the accounting is made from electronic health records, in which case the period of time can be no longer than 3 years*). I understand that the first accounting I request in any 12 month period will be given to me for free. I also understand that if I request more than one accounting in a 12 month period that I will be charged the cost to Erie County for completing this accounting.

3. Please indicate your preferred method of receiving the accounting:

   ☐ on paper ☐ electronically

SIGNATURE AND VERIFICATION

I have read, understand and had an opportunity to ask questions about this form. I further understand that under certain circumstances, Erie County may deny this request.

SIGNATURE: _____ DATE: _____

NAME AND ADDRESS OF PERSONAL REPRESENTATIVE (if applicable):

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (supporting documentation is required):

- ☐ Parent
- ☐ Court-Appointed Guardian
- ☐ Health Care Agent
- ☐ Power of Attorney
- ☐ Administrator/Executor
- ☐ Other: _____

VERIFICATION REQUIREMENTS

For in-person requests for an amendment of health information, patients and authorized representatives can meet verification requirements with one of the following:

☐ In-person patient request verified by government-issued photo identification (copy of ID to be retained with request)

☐ In-person request by authorized third party - parent, legal guardian, or other court-appointed representative verified by government issued photo ID *and* copy of appointing document (copy to be retained with request)

Notarization is required for requests submitted to Erie County by mail. An authorized representative must also submit a copy of the appointing document. The notary public or other officer authorized to take and certify acknowledgments and administer oaths must complete the following:

STATE OF NEW YORK

COUNTY OF _____

On the _____ day of _____ in the year _____ before me, the individual referenced above, personally appeared and proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this form and acknowledged to me that he or she executed the same in his or her capacity, and that by his or her signature(s) on the form, the individual executed the form.

_____
Notary Public

Printed Name: _____ My Commission Expires: _____

FOR ADMINISTRATIVE USE ONLY: Date Received: _____ Request has been: ☐ Accepted ☐ Denied

Staff member: _____ Title: _____