

**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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client Name (printed) Date of request*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of client, parent, or legal guardian*

=====================================================================

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

|  |  |
| --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_