TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Date: _____

Name: _____

Date of birth: _____

I would like an accounting of how my protected health information was disclosed by Torrance Memorial Medical Center, as required by federal regulations. I understand that TORRANCE MEMORIAL does **NOT** have to tell me about the following types of disclosures:

1. Disclosures for purposes of treatment, payment and health care operations or as part of a limited data set.
2. Disclosures to me or disclosures authorized by me.
3. Disclosures for use in the hospital's directory.
4. Disclosures to persons involved in my care.
5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).
6. For national security or intelligence purposes.
7. To correctional institutions or law enforcement officials.
8. Disclosures made prior to April 14, 2003.
9. Disclosures incident to a use or disclosure otherwise permitted or required by state or federal law.

I also understand that my right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

I want an accounting of disclosures that covers the following time period:

_____

(Note: the time period must be no longer than six years and may not include dates before April 14, 2003.)

☐ Please send my accounting to the following address:

_____

_____

_____

☐ I want to pick up the accounting. Please call me at the following phone number when it is ready: _____.

I understand that the hospital must give me the accounting of disclosures within 60 days, or tell me that it needs an extra 30 days (or less) to prepare it.

I am entitled to one free accounting of disclosures in any 12 month period. Additional accountings will cost $40 each.

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website www.torrancememorial.org or contact the Health Information Management Department 310.517.4721..

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact the HIPAA Privacy Officer at 310-325-9110, ext. 22069. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Signature of Patient or Representative:
If Representative, give relationship:
Date: