Patient Request for Accounting of Disclosures

Place Patient Label Here

Mail, Fax or Drop off completed form at the following locations - Health Information Management Dept. - ROI

Good Samaritan Regional Medical Center
P.O. Box 2728
Corvallis, OR 97330
Fax: 541/768-5389

Samaritan Albany General Hospital
1046 Sixth Ave. SW
Albany, OR
Fax: 541/812-4139

Samaritan Lebanon Community Hospital
P.O. Box 739
Lebanon, OR
Fax: 541/451-7071

Samaritan North/ Lincoln Hospital
P.O. Box 767
Lincoln City, OR 97367
Fax: 541/996-7310

Samaritan Pacific Communities Hospital
930 SW Abbey St.
Newport, OR 97635
Fax: 541/574-1836

Patient Name ______________________ Date of Birth ______________ Medical Record # ______________

This is a request that Samaritan Health Services (SHS) provide a list of disclosures of my medical information.

Before signing this request, please consider:

- The list will not include disclosures made more than six years before this request or made earlier than April 14, 2003.
- This list will not include disclosures of medical information related to treatment, payment, or health care operations.
- Disclosures that may not be listed include, but are not limited to use or disclosures (a) that you or your personal representative authorized; (b) to persons (family, friends, etc.) involved in the care or payment of health care of the patient; (c) made incidentally as permitted or required; (d) as part of a limited data set; and (e) for national security or intelligence purposes.

Your Rights when Requesting an Accounting of Disclosures:

- You have a right to request an accounting of disclosures made by us of your medical information.
- You have a right to receive a response to this request within 60 days. If there are potential delays in that response, you will be notified in writing, this delay cannot be more than an additional 30 days.
- There is no charge for the first request in a 12-month period, however charges will be assessed for subsequent requests within the same 12-month period.

I am requesting a list of disclosures of my medical records for the following period of time: (be specific)

From: ____________________/___________ To: ____________________/ ___________

Month Year Month Year

Signature of patient ______________________

Signature of person authorized by law to sign for patient ______________________

Date ______________________

Relationship to patient ______________________

Witness ______________________

Date ______________________

Your Right to File a Privacy Complaint:

Privacy complaints can be filed with the SHS Privacy Officer or with the U.S. Department of Health and Human Services, Office for Civil Rights. See contact information below

Samaritan Health Services Attn: Privacy Officer
3600 NW Samaritan Drive Corvallis, Oregon 97330
Phone: (541) 768-2165
Email: privacy@samhealth.org

Office for Civil Rights, Region X
U.S. Department of Health and Human Services 2201 Sixth Avenue - Mail Stop RX-11
Seattle, Washington 98121-1831
Phone: (206) 615-2290