

**SOUND INPATIENT PHYSICIANS, INC.**  
**REQUEST FOR ACCOUNTING OF DISCLOSURES FORM**

I hereby request that Sound provide an accounting of the disclosures of health care information regarding the following patient:

PATIENT NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

DATES FOR WHICH YOU ARE REQUESTING AN ACCOUNTING (may not be more than six years prior to the date of your request, unless the accounting being requested relates to disclosures for treatment, payment or health care operations purposes made through an electronic health record, in which case the dates may not be more than three years prior to the date of your request):

FROM DATE: \_\_\_\_\_ TO DATE: \_\_\_\_\_

*Note: No accounting is available for disclosures that occurred prior to April 14, 2003 or for the disclosures specified above that are made through an electronic health record prior to the effective date set by the Secretary of the U.S. Department of Health and Human Services .*

If you want to limit the accounting to those disclosures made to a specific person or entity, please identify that person or entity here. If this section is left blank, an accounting of *all* disclosures made during the time period listed above (except those that the law does not require or allow us to list) will be provided:

\_\_\_\_\_

*If you are not the patient, please fill out the following information:*

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Telephone (if different from above): \_\_\_\_\_

*Please furnish a copy of any conservator/guardianship papers with this request.*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**All requests for accountings must be submitted in writing to:**

James Kodjababian, Privacy Officer  
Sound Inpatient Physicians, Inc.  
1123 Pacific Avenue  
Tacoma, WA 98422

*WE WILL PROVIDE THE FIRST ACCOUNTING IN ANY TWELVE MONTH PERIOD FREE OF CHARGE. FOR EACH ADDITIONAL ACCOUNTING DURING THAT TIME, WE WILL CHARGE A REASONABLE FEE BASED ON OUR COSTS. WE WILL NOTIFY YOU OF THE AMOUNT OF THIS FEE IN ADVANCE SO THAT YOU HAVE AN OPPORTUNITY TO WITHDRAW OR CHANGE YOUR REQUEST.*