Accounting of Disclosure Request Form

CRISP Shared Services (CSS), on behalf of its health information exchange (HIE) members, offers patients the opportunity to request an accounting of disclosures of their medical records contained within the CSS database. This request, which may be made twice a year free of charge, will inform you which healthcare providers, if any, have accessed your medical records through the HIE. Upon receipt of your completed request, CSS will begin to process your accounting of disclosures report. Please note that, if you are requesting an accounting of disclosures on behalf of someone else, such as a minor child, CSS staff may contact you regarding any additional documentation that may be needed to complete your request. A request is considered complete once CSS has received all of the information necessary to process the request. If you provide us with your e-mail address in the form below, you will receive an e-mail acknowledgment of receipt of your completed request.

The results of your accounting of disclosures request will be sent to you within 30 days of receipt of your *completed* request. If you request to receive your accounting of disclosures report via e-mail, and more than 30 days pass without receiving your report, please check your spam/junk folder.

Records of disclosures date back at least 6 years from the date of the requested accounting.

Instructions:

In order to submit your request, please complete the second page of this form. You **must** also include a scanned/photographed copy of your government-issued photo ID (e.g., driver's license, passport, identification card).

This completed form and the copy of your photo ID should be sent to CSS via one of the following:

1) By E-mail:
   Disclosures@crisphealth.org

2) By Mail:
   CRISP Shared Services
   Attn: Nichole Sweeney, Privacy Officer
   7160 Columbia Gateway Drive
   Suite 100
   Columbia, MD 21046

3) By Fax:
   Attn: CSS Privacy Team
   Subject: Accounting of Disclosures Request
   443-817-9587

Please complete ALL of the following fields based on the individual who is the subject of the accounting of disclosures request:

Patient First Name: _____

Patient Last Name: _____

Street Address: _____

City, State, Zip: _____

Date of Birth (mm/dd/yyyy): _____

***If you are submitting this form on behalf of someone else*, you must complete this section.**

Requestor First Name: _____

Requestor Last Name: _____

You are acting as one of the following:

◯ Parent ◯ Legal Guardian ◯ Executor ◯ Other: _____

*If you are submitting this form on behalf of someone else, **we <u>will</u> reach out to you to request additional documentation**. Providing your e-mail address below will greatly expedite that process.

By not completing this section, you attest that you are making this request on your own behalf.

Please indicate how you would like to receive the accounting of disclosures report:

◯ E-mail ◯ Mail

Even if you choose to receive your accounting of disclosures report via e-mail, providing your e-mail address can speed up your request by allowing us to reach out to you more quickly if we have questions or need additional documentation to fulfill your request.

E-mail Address: _____

_____ _____

Signature of Patient or Legal Representative Date