Protected Health Information Disclosure List Request Form

To request a list of the individuals, institutions, or organizations to which BMC has disclosed your protected health information, you must complete, sign and return this form to:

Privacy Officer
Medical Records Department
850 Harrison Avenue/ACC Basement
BR-09E
Boston, MA 02118

Or submit via fax to: 617-638-7416. For questions, contact 617-414-1800

Demographic Information (*Please complete and sign where appropriate***)**

Patient Name: _____
Last First MI

Address: _____
Street City State/Zip Code

BMC's MR #: _____ Telephone #: _____

Birth Date: _____/ _____/_____ Alternate Telephone #: _____

Address to send list of disclosures (if different than above):

Address: _____
Street City State/Zip Code

Disclosure List Date Range

I would like a list of disclosures for the following time period.

From: _____To: _____

Please Note: ***The list of disclosures is not available for disclosures prior to April 14, 2003.***

Fees: The first request in any 12-month period is free.

I understand that after the first request in a 12-month period there is a fee for the List of Disclosures and I wish to proceed. I also understand that list will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or special condition.

_____ _____
Patient's Signature **Date**

_____ _____
Patient's/Legal Representative's Signature **Date**

BMC USE ONLY

Date Received: _____ Date Responded: _____

❑ Extension Requested:

Reason:_____

Is this the first request for accounting in a 12-month period? Yes: ☐ No: ☐
If no, has patient paid in full? Yes: ☐ No: ☐

Privacy Officer's Signature/Date

Please make a copy of this request for your records

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