Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
Post Office Box 320 • 200 Gwee-Shut RD
Siletz, OR 97380
Telephone: 800-648-0449 • (541)444-1030
Facsimile: (541)444-9695

REQUEST FOR ACCOUNTING OF DISCLOSURES

Complete and return this form to the above address to the attention HEALTH INFORMATION STAFF.

Date of Request	Patient's Name (First Middle Initial and Last)
Date of Birth	Mailing Address
Phone Number	

I am requesting for an accounting of disclosures by the Siletz Community Health Clinic (SCHC) for the following period (example 01/01/18 to 01/30/18):

From: _____ To: _____

If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/organization, please describe which disclosures you seek for accounting:

I understand SCHC will provide the accounting disclosures within 60-days of the date of this request, unless SCHC extend for additional 30-days and provides me with a written statement for the reason(s) for the delay and the date I may expect to receive the accounting.

Print name, sign and date. If your signature is your mark or thumbprint then your Representative or Witness will need to sign and state their relationship to you.

Print Patient's Name (First, Middle Initial and Last)	Date Signed
Signature of Patient	Mark or Thumb Print

Signature of Personal Representative or Witness	Relationship

SCHC HEALTH INFORMATION USE ONLY:

Name, Title of SCHC Employee processing request			
MRN	Date Received	Date Sent	Scanned