TELEMYND

Request for an Accounting of Disclosures

Individual requesting Accounting

Name: Date of Birth:
Address:
Client I.D. Number:
Telephone: Email:
Date of Request:

Telemynd will provide an accounting of certain disclosures of your protected health information. Your accounting will not include, for example, disclosures Telemynd made for purposes of treatment, payment, or health care operations. Nor will your accounting include disclosures that took place more than six years ago. Telemynd reserves the right to charge a fee if you request more than one disclosure accounting within a twelve-month period.

I'm requesting an accounting of disclosures for the following time frame *(e.g., from 01/09/2020 to 01/30/2020)*

From: To:

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

I understand the accounting will be provided to me within 60 days of the date of receipt of this request, unless Telemynd extends the time frame for an additional 30 days and provides me with a written statement of the reason(s) for the delay and the date by which I can expect to receive the accounting. Telemynd will send this accounting to the current address Telemynd has for me in its records. If the information on this form is not complete, Telemynd will return the form to you, and this request will not be considered until Telemynd has received complete information.

The individual named above should be the person signing this request form. If the member is a minor, a parent or legal guardian must sign. If this form is completed by a Legal Representative, other than a parent (i.e., a person who has legal authority to act on the member's behalf), please ensure you have submitted the proper legal documentation giving you such authority with this request.

SIGNATURE

Print Name: _____

Signature: _____ Date: _____

Parent/Guardian/Personal Representative

Print name: _____

Signature: _____ Date: _____

Please send completed form to: HIPAA/Privacy Officer
141 Parker Street, Suite 306, Maynard, MA 01754

PLEASE KEEP A COPY OF THIS REQUEST FOR YOUR RECORDS.