Restore Medical Fitness
4545 Transit Rd.
Williamsville, NY 14221
716-906-2102

HIPAA Compliance Office
Maria Kreher

F-1005 HIPAA – Accounting of Disclosure Request

PATIENT INFORMATION

Date

Name (Last, first, middle initial)

Date of Birth

Street address, City, ST, ZIP Code

Email address

Primary phone number | Other phone number

Fax number

I, ____, am requesting an account of disclosure report for my health records

(Full Name)

Please provide any additional details of the accounting of disclosure request.

Method of Release (Select one)

☐ In person ☐ Mailed (address listed above) ☐ Fax (as listed above)

Do you authorize anyone to receive the requested items on your behalf?

☐ No ☐ Yes, I authorize ______________________________ to receive the requested items

Relation to requestee ____

Please indicate an acceptable method of contact (Select all that apply)

By selecting this method of contact I am giving Restore Medical Fitness my consent to contact me by the indicated means when the requested items are available.

☐ Mailing Address (as listed above) ☐ Primary Phone (as listed above)
☐ Email (as listed above) ☐ Other Phone (as listed above)

Do you authorize Restore Medical Fitness to leave a phone message?

☐ Yes ☐ No

Please list Restore Medical Fitness staff member that was contacted regarding this matter:

Name

Date

Signature

Date

Depending on the size of the request, Restore Medical Fitness may require up to 30 days to complete the request and will contact you when a printed file is available.

(Attach additional documentation, if applicable.)

For Administrative Use Only:

Date received

Action taken

Date

Action taken

Date

Privacy Official signature

Date