

# SHEPHERD'S STAFF CHRISTIAN COUNSELING CENTER

## **Accounting of Non-Authorized Use or Disclosure Request Form**

I, \_\_\_\_\_, request that Shepherd's Staff Christian Counseling Center, Inc. provide me with an accounting of any and all applicable "non-authorized" uses and disclosures of my protected health information (PHI) between \_\_\_\_\_ (beginning date) and \_\_\_\_\_ (ending date).

I would like to limit this request for accounting to include disclosures only pertaining to:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I may be charged for this information if I have previously requested this information within the last 12 months. I have been informed of the approximate cost of \$15.00 plus 50 cents per page, and agree to be financially responsible for this charge.

Patient signature: \_\_\_\_\_

Printed name and date of birth: \_\_\_\_\_

Date: \_\_\_\_\_

Date received by Privacy Officer \_\_\_\_\_ Signature \_\_\_\_\_