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STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR AN ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

INDIVIDUAL INFORMATION

INDIVIDUAL'S NAME	SOCIAL SECURITY NUMBER
BIRTH DATE	OTHER IDENTIFIER (E.G., DCN)
ADDRESS	
CITY/STATE/ZIP CODE	

NAME AND ADDRESS TO SEND ACCOUNTING OF DISCLOSURE (IF DIFFERENT THAN ABOVE)

NAME	ADDRESS
CITY/STATE/ZIP CODE	

IF THIS REQUEST IS MADE BY SOMEONE OTHER THAN INDIVIDUAL, STATE RELATIONSHIP AND AUTHORITY TO MAKE REQUEST.

Individual is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Healthcare ☐ Authorized Legal Representative

DATE RANGE REQUESTED

I would like an accounting of all disclosures for the following timeframe. ***Note:*** *The maximum timeframe that can be requested is six years prior to the date of your request.*

FROM	TO

FEES

There is no charge for the first accounting request in a 12-month period.

For subsequent requests in the same 12-month period, the charge is $ _____ .

I understand that there is (check one):

☐ No fee for this request. ☐ A fee for this request in the amount specified above, and I wish to proceed.

RESPONSE TIME

I understand the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

INDIVIDUAL OR PERSONAL REPRESENTATIVE SIGNATURE	DATE

FOR DSS USE ONLY

DATE REQUEST RECEIVED	DATE ACCOUNTING SENT

EXTENSION REQUESTED ☐ YES ☐ NO	INDIVIDUAL NOTIFIED IN WRITING ON THIS DATE

DSS PRIVACY OFFICER OR DESIGNEE SIGNATURE

Submit this form to the DSS Privacy Officer, PO Box 1527, Jefferson City, MO 65102