HENRY FORD HEALTH

Patient Request for an Accounting of Disclosures (AOD)

Place patient label here or fill out information below:

Patient Name: ____________________________

Date of Birth: ___________________

MRN: ___________________________

As a patient, I, my personal representative, or legal guardian have the right to know who Henry Ford Health (HFH) has shared my protected health information (patient information) with. This is called an accounting of disclosures (AOD), and includes certain patient information that has been shared by HFH or any of its business associates.

An AOD does not include the sharing of my patient information for the following purposes:

- Treatment, payment, or healthcare operations.
- Disclosures made to me, my personal representative or guardian.
- Disclosures made with permission from me, my personal representative or guardian.
- Disclosures that do not require to be accounted for by law.

To receive an AOD please complete this form. When complete, return this form by one of the following options:

- **Mail:**
  Henry Ford Health - Health Information Management Department
  1414 E Maple Road
  Troy, MI 48083
- **Email:** HFHSMedicalRecords@hfhs.org Be aware that email may not be secure and the information could be viewed while in transit.
- **Fax:** (313) 916-3917

Requestor Information

Fill out all of the information below and on the next page. If the requestor is the personal representative, attach certifying documentation of status as the personal representative, such as a Durable Medical Power of Attorney or Guardianship documents.

______________________________	________________	________________
Name of Patient	Medical Record Number	Date of Birth

Requested By (if other than patient):

______________________________	______________________________
Personal Representative Name	Relationship to Patient

Patient/Requestor Contact Information

______________________________	______________________________
Address (Street address, city, state, zip code)	Telephone Number

______________________________	______________	__________
Patient or Requestor Signature	**Date**	**Time**

The dates of disclosures I want HFH to account for are:

☐ From: ____/____/____ to ____/____/____(may not exceed 6 years)

For HFH Use Only

Date Received: ____________ Processed By: _________________ Accounting Sent Date______________

Date scanned into medical record: _______________