



REQUEST FOR ACCOUNTING

This FORM is for a patient who wants a list of disclosures of their *Protected Health Information* (an "Accounting").

I wish to receive an Accounting of disclosures of my Protected Health Information, pursuant to Section 164.528 of the HIPAA Privacy Regulation, made by Rite Aid. I understand that:

- (1) disclosures made for the purpose of treatment, payment, and health care operations will be excluded;
- (2) disclosures made directly to the patient or to patient's family members or friends involved in the patient's care will be excluded;
- (3) disclosures made for purposes specifically authorized by the patient will be excluded;
- (4) the right to receive an Accounting is subject to certain other exceptions, restrictions, and limitations;
- (5) the accounting period may not be longer than six (6) months prior to the date of my request.

I am the patient making the request concerning disclosure of my own *Protected Health Information* or I am the patient's personal legal representative as indicated below.

**Accounting Period:** From \_\_\_\_\_ to \_\_\_\_\_.  
(Beginning Date) (Ending Date)

(Please Print Clearly)

**Name of Patient:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

If other than patient or parent, proof of authority to sign must accompany this form.

☐ Patient ☐ Parent or Guardian ☐ Power of Attorney ☐ Court Appointed

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Mail to:**

**Privacy Office, Rite Aid P.O. Box 3165, Harrisburg, PA 17105**

**or fax to: 717-975-5952**

September 2022