

REQUEST FOR ACCOUNTING OF DISCLOSURE FORM

45 CFR §164.512

This form allows patients or their personal representatives to request an accounting of certain disclosures of the patient's medical and health information made by Baylor Genetics. Please submit the completed form to the address below or compliance@baylorgenetics.com. Unless an extension is requested, you will receive a response within sixty (60) days from receipt of this completed form.

Attn: Baylor Genetics Compliance
2450 Holcombe Blvd.
Suite 2210
Houston, TX 77021

PATIENT INFORMATION

____/____/____ Requested Date (MM/DD/YYYY)	_____ Patient's Full Name	
____/____/____ Birth Date (MM/DD/YYYY)	_____ Phone Number	_____ Fax Number
_____ Email Address		

LOCATION TO SEND ACCOUNT

USPS
Address _____ City _____ State _____ Zip _____

Email (secure) _____

Other _____

TIME PERIOD OF DISCLOSURE

Provide the period for which you wish to see the disclosures made. It cannot be more than six (6) years prior to the date of your request.

From _____ To _____

WHAT DISCLOSURES ARE NOT INCLUDED

Baylor Genetics is not required to include in the accounting the following disclosures:

- Pursuant to an Authorization
- To the patient/Personal Representative
- For treatment/payment/health care operations
- To persons involved in your care
- For national security/intelligence purposes

FEES

If you request more than one (1) accounting in any 12-month period, Baylor Genetics may charge you a reasonable, cost-based fee for each subsequent accounting requested.

SIGNATURES

_____ Patient's Signature	____/____/____ Date Signed (MM/DD/YYYY)	_____ Patient's Personal Representative* Signature	____/____/____ Date Signed (MM/DD/YYYY)
_____ Printed Name		_____ Relationship to Patient	

*Attach documentation demonstrating authority to act on behalf of the patient, if applicable (e.g., a valid power of attorney letter, court order, guardianship papers, etc.).