Ohio Department of Medicaid

REQUEST FOR ACCOUNTING FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date of Request	
Recipient Name	DOB
Recipient Address	

DATES REQUESTED:

(Please note: The earliest disclosure that can be requested is six years prior to the date of request).

I WOULD LIKE AN ACCOUNTING OF ALL DISCLOSURES FOR THE FOLLOWING TIME FRAME:

FROM _____ /____ /_____ *(MM/DD/YYYY)*

TO _____/_____/_____ *(MM/DD/YYYY)*

I UNDERSTAND THAT THE ACCOUNTING WILL BE PROVIDED TO ME WITHIN 60 DAYS OF RECEIPT BY ODM UNLESS I AM NOTIFIED IN WRITING THAT AN EXTENSION OF UP TO 30 DAYS IS NEEDED.

Signature of Recipient or Personal Representative	Date

REQUEST **WILL NOT** BE APPROVED WITHOUT ID VERIFICATION – COPY OF;

- **Medicaid ID Card or**
- **Social Security Card plus Driver's License and State ID must be attached**

FOR INTERNAL USE ONLY			
Postmark Date	Date Received	Date Sent	
Extension? ☐ Yes ☐ No / Date	Reason		
Recipient notified in writing on this date	Bureau	Section	Processed By

DISTRIBUTION: Send completed form to the Ohio Department of Medicaid, Attn: Health Information Privacy Official, PO Box 182709, Columbus, OH 43218-2709

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Formerly JFS 03398