FLEXOGENIX, INC.
PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name: _____ *Medical Record Number:* _____

Date of Birth: _____ *Phone Number:* _____

Patient Address: _____

I request Flexogenix, Inc. provide me with an accounting of any and all applicable disclosures of my protected health information between _____ (beginning date) and _____ (ending date).

I understand that my accounting of disclosures will not include disclosures made under certain circumstances: treatment, payment, or health care operations, pursuant to your authorization, as part of a limited data set, or disclosures made prior to February 4, 2019.

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

I understand that I may be charged for this information if I have previously requested medical record information. I have been informed of the $10.00 charge and agree to be financially responsible for this charge.

_____ _____ _____

Signature of Patient or Authorized Representative *Date* *Time*

If signing as authorized representative, describe authority to act for patient and submit documentation showing such authority: _____

Address to send this accounting to:

- ☐ Send accounting to the above address.
- ☐ Send accounting to the following address: _____

FLEXOGENIX, INC. USE ONLY

Date request received: _____ *Date request sent:* _____

Extension requested (circle one): YES NO

If yes, reason for extension: _____

Other Comments: _____

Signature of staff member: _____ *Date/Time:* _____

Staff Member (Print Name): _____