St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177

Tel: (340)775-3700
Fax: (340)777-7927

"Your Health is our First Priority"

Request for an Accounting of Disclosures

Patient Name: ______________________________________ Date of Request: ________________

Pt # _______________ Date of Birth: __________________ Phone # ________________________

I would like an accounting of disclosure for the following time frame (e.g., From: 01/01/2009 To: 01/03/2009)

From: __________________To:__________________

If you are only seeking an accounting of a certain type(s) of disclosure of disclosures to a specific person/organization, please describe the disclosures for which you are seeking an accounting:

I understand that the accounting will be provided to me within 60 days of the date of this request unless STEEMCC extends the time frame for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive the accounting.

Signature: ____ Date: __________________________

Please print relationship to patient (if signed by a personal representative of patient):

____

Mail or email the completed signed form to: Attention: Privacy Officer
St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177
Email: privacyofficer@steemcc.org

OFFICIAL USE

PT# _____________________

HIM Manager:_____________________________________ Date:___________________________

Privacy Officer: __________________________________ Date:___________________________