IHS-913 (4/09)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 1/31/2013
See OMB Statement below.

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

DATE OF REQUEST	PATIENT NAME

HEALTH RECORD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

The information is to be disclosed by:

NAME OF FACILITY

ADDRESS

CITY	STATE

I would like an accounting of disclosures for the following time frame (e.g., From: 01/01/09 To: 01/30/09)

From: _____ To: _____

If you are only seeking an accounting of a certain type(s) of disclosure or 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 IHS 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 OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

FOR IHS USE ONLY

DATE RECEIVED	DATE SENT

NAME/TITLE OF IHS EMPLOYEE PROCESSING REQUEST

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, 801 Thompson Ave., TMP Suite 450, Rockville, MD 20852, RE: PRA 0917-0030. Please DO NOT SEND this form to this address.