SABLE ALTURA FIRE PROTECTION DISTRICT

Patient Request for Accounting

Patient Name:_____ Date:_____

Address:_____

City:_____ State:_____ ZIP Code:_____

Date of Birth:_____ Social Security Number:___ - ____ - _____

Your Rights as a Patient: As a patient, you have the right to request an accounting of certain used and disclosures of your Protected Health Information by the Sable Altura Fire Protection District (the "District") for the six (6) years prior to the date of your request. However, the District is not required to provide you with an accounting of uses and disclosures associated with your treatment and transport, or for billing, payment or health care operations.

Patient Signature:_____ Date:_____

List of Uses and Disclosures

Date of Disclosure	Name/Address of Recipient	Purpose and Brief Description of Disclosure	Protected Health Information Disclosed