

PROGRESSIVE MEDICAL, INC.
REQUEST FOR ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

Progressive Medical, Inc. will provide you with an accounting of certain disclosures of your protected health information. You will NOT receive an accounting of the following:

- Any disclosure for the purpose of treatment, payment, or the day-to-day operation of the practice (i.e., any disclosures of information permitted under the patient's consent to the use and disclosure of protected health information)
- Any disclosure to the patient himself or herself
- Any disclosure for use in a facility directory
- Any disclosure to national security or intelligence agencies that is required by law
- Any disclosure to correctional institutions or law enforcement agencies that is required by law
- Any disclosure that occurred prior to April 14, 2003, the effective date of the HIPAA privacy rules

We will contact you when the information you have requested is available (within approximately 60 days of your request).

NOTE TO AUTHORIZED REPRESENTATIVES: If an Authorized Representative is signing this form on behalf of the patient, additional documentation supporting the authorization to disclose patient information, such as a Power of Attorney for healthcare, must be submitted in order for records to be provided.

Name of Patient (print):		
Signature of Patient or Authorized Representative:		Date:
Relationship of Personal Representative to Patient or Statement of Authority: (if applicable)		

SUBMIT THIS FORM TO ADDRESS BELOW, OR FAX TO 614-212-8008

Progressive Medical, Inc. Attn: Medical Records
250 Progressive Way
Westerville, OH 43082
Fax: (614) 212-8008