

Request for Accounting of Disclosures of Health Information

I, _____ (if legal
Print name of - **Circle One:** (Applicant, Recipient, Legal Representative)
Representative), _____ request the
(Description of Legal Representative's Authority)

Med-QUEST Division (MQD) to provide an accounting of disclosures of protected health information that MQD has made for the following time period ____/____/____ to -
____/____/____ (not to exceed 6 years and not for period before April 14, 2003):

I understand MQD will let me know within 60 days when the information requested is available or that an additional extension of 30 days may be required.

My mailing address is:

_____ Mailing Address

City State Zip Code

My telephone number is:

Authorized Signature:

Notice of Availability

For MQD use only

MQD has reviewed your request and shall:

- Make the information requested available to you on ____/____/____ at the following location _____.
- Require an additional 30 days to comply with your request.

If you require more information, please contact:

MQD Administration
P.O. Box 700190
Kapolei, HI 96709-0190