DIABETES ASSOCIATES MEDICAL GROUP

Accounting of Non-Authorized Use or Disclosure Request Form

I, _____, request that Dr. Ivy-Joan Madu's Office provide me with an accounting of any and all non-authorized uses and

disclosures of my protected health information (PHI) since _____ (date).

I understand that I may be charged for this information. I have been informed of the approximate cost of $50.00, and agree to be financially responsible for this charge.

Patient signature: _____

Date: _____

Privacy Officer Action/Comments: