Request for Accounting

Effective date of this notice: 04/16/2020

Individual Name: ______________________
Individual Address ______________________
Date of Birth: ______________________
SSN: ______________________
Specimen Identification No: ______________________

Please consider this a request for the exercise of my rights under federal and state laws to request confidential communications of my Personal Information

Describe the Personal Information for which you would like an accounting.

Date Range of this Request
From ______________________ to ______________________

Please consider this a request for an accounting of all disclosures for the time frames indicated below. (The maximum time frame that can be requested is six (6) years prior to the date of the request, but not before April 14, 2003.)

Signature: ______________________ Date: ______________________

Please Mail Form to:
Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215