Please print:

First name:	Last name:	Middle initial:	Date of Birth:

Street Address:	Apt. #:	City:	State:	Zip Code:

Phone number(s):	Preferred email address:

As a patient receiving health care services from NYBC you may receive an accounting of disclosures of your health information for purposes other than treatment, payment for care, or administrative activities. Please note that you may be charged a fee if requesting an accounting more than once in a 12-month period. You will be notified in advance of any such processing fees.

Specify the dates to which the account applies:	Start date:
	End date:

Patient/Agent/Surrogate/Guardian* (Signature):	Date:

Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):

**The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions.*

Submit completed form to:

New York Blood Center
Attention: Privacy Officer
310 East 67th St
New York, NY 10065

Via **Fax:**
516-478-5040

Via **email:**
PrivacyOfficer@nybc.org

To be completed by NYBC Privacy Officer or Healthcare Provider

Signature:	Date:

Printed name:	Title: