Attachment A to Policy 07-02-04
SAMPLE FORM
Patient/Individual Request for Accounting
of Disclosures of Protected Health Information

Date of Request: ____________________________________

Patient/Individual Name: ____

Medical Record No.: ___________

Social Security Number (last 4 digits): ___________________ DOB: _______________________

Telephone Number: __________________________________

Patient/Individual Address: ____

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Address to send disclosure accounting (if different than above):

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University School/Department/Unit Accounting to be Requested From:

____ _________________________

School/Department/Unit Date of Service

I understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed. I also understand that the following disclosures are excluded from tracking: Disclosures made for treatment, hospital payment and healthcare operations; disclosures to the patient; disclosures made pursuant to a valid authorization, disclosures made for facility directory purposes; disclosures made to persons involved in the patient's care; national security or intelligence disclosures, and disclosures to correctional institutions or law enforcement. I understand that the University is not required to track disclosures made prior to the implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. I understand that the University is only required to maintain disclosures for a maximum time period of six (6) years prior to the date the accounting is requested according to the HIPAA Privacy Regulations.

____ _________________________

Signature of Patient/Individual or Legal Representative Date

For University Use Only:

Date Received: _______________________________ Date Sent: ______________________________

Extension Requested: No ☐ Yes ☐ Reason for Extension: ___________________________________

Patient Notified in Writing on this Date: ____

Staff Member/Title Processing Request: ____

If applicable, Business Associates contacted: _______________________________________

* For patients/Individuals requesting accounting of disclosures from multiple University Schools/departments/units, please document date(s) request(s) forwarded to other facilities.

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