Patient Name(s)

Medical Record #

Date of Birth

Contact Phone #

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

I, ________________________________, (Print Name) request an accounting of disclosures of my health or billing information for the period FROM: __________________________ TO: ___________________________

Name of Provider(s) seen: ____

Send accounting to:

- ☐ This address: ____
- ☐ I will pick up the accounting in person. Please contact me at _______________________when document (s) is/are ready.
- ☐ Fax Number: ____

I understand that this accounting of disclosures will include all disclosures ***except*** those:

- To whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out UCCS's Designated Health Care Component health care business operations.
- To myself or my personal representative.
- Incidental disclosures made in connection with a use or disclosure otherwise permitted or required by HIPAA.
- To persons involved in my care or as part of an inpatient directory.
- Pursuant to an authorization for release of information signed by myself or my personal representative.
- For national security or intelligence purposes, to correctional institutions, or to law enforcement officials under certain circumstances.
- To correctional institutions or law enforcement officials under certain circumstances.
- As part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health, or certain health care operations purposes.
- That occurred prior to April 14, 2003 or that designated site becoming a HIPAA covered entity.

I understand that this accounting will include all disclosures of HIV-related information except disclosures made to:

- Federal, state, or local health officers that are required or permitted by law.
- Persons reviewing information or records in the ordinary course of ensuring that a health facility is in compliance with applicable quality of care standards, program evaluation, program monitoring or service review.
- Life and health insurers, government payers and health care centers in connection with underwriting and claim activity for life, health, and disability benefits.

I understand that I may receive the first accounting for disclosures within a 12-month period at no charge. I understand that if I am requesting a second or subsequent accounting in a 12-month period, I will be charged a flat fee for this accounting. This fee is to cover the cost of supplies, labor and postage associated with copying. I further understand that if I do not ask you to proceed with my request, I may modify my request to reduce the fee or withdraw my request and pay no fee.

____ _______________________________

Signature of Patient or Authorized Representative **Date of Signature**

____ _______________________________

Printed Name **Relationship to Patient (if applicable)**