REQUEST FOR AN ACCOUNTING OF DISCLOSURES

PATIENT INFORMATION

Medical Record #: _____

Patient's name (print): _____ Date of Birth: _____

Address: _____

City: _____ Daytime phone #: (____) _____

State: _____ Zip Code: _____ Evening phone #: (____) _____

Print name and address to send accounting of disclosure, if different from above:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ACCOUNTING OF DISCLOSURES REQUESTED FROM

Name of the UR Medicine hospital / health care facility / physician practice from which accounting is requested:

_____

DATES REQUESTED

I would like an accounting of all disclosures for the following timeframe.

Dates of accounting from: _____ / _____ / _____ to: _____ / _____ / _____

Please note: the maximum time frame that can be requested is six years prior to the date of your request. We will not be able to include disclosures that were made before 4/14/2003, since we were not required to collect this information until after that date.

FEES

There is no charge for the first accounting request in a 12-month period per UR Medicine facility. For subsequent requests from the same facility within a 12-month period, a fee may be charged. You will be notified in writing of any fee associated with this request.

RESPONSE TIME

I understand the accounting I have requested should be provided to me within 60 days. I will be notified in writing if an extension of up to 30 additional days is needed to fulfill my request.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship if Legal Representative: _____

FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: _____ Due 60 days on: _____ 30-day extension due: _____

Extension requested: ☐ Yes ☐ No Date Extension letter sent: _____

☐ No fee for this request *or* Date fee letter sent: _____ Amout: _____

Date Fee received or request altered: _____

Date accounting sent: _____ Processed by: _____

Retain this form with the completed Accounting of Disclosures provided to patient for 6 years

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