OSU MEDICINE
REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name: _____ Date of Birth: _____

Address: _____

YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an Accounting of Disclosures of your Protected Health Information made by OSU Medicine for a period of up to 6 years prior to the date of the request. The first accounting in a 12-month period is free of charge. A reasonable, cost-based fee may be charged for additional accountings. The accounting will include all disclosures, **EXCEPT** for the following:

1. To carry out treatment, payment, and health care operations;
2. To individuals of Protected Health Information about themselves;
3. Incident to a use or disclosure permitted by the Privacy Regulations;
4. Pursuant to the individual's authorization;
5. For a facility directory, to persons involved in the individual's care or for other notification purposes;
6. For National Security or Intelligence purposes;
7. To correctional institutions or law enforcement officials about a person in their custody; or
8. As part of a limited data set.

REQUEST FOR ACCOUNTING OF DISCLOSURES

I request an accounting of disclosures for the period from _____ to _____ (max 6 years).

Please mail the accounting to me at the following address: _____

_____

I understand the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to an additional 30 days is needed.

Signature: _____ Date: _____
Patient or Legal Representative

Printed Name and Authority of Legal Representative (if applicable): _____

RETURN THIS FORM TO: OSU CHS COMPLIANCE OFFICE, 717 S HOUSTON, SUITE 510, TULSA, OK 74127

FOR OSU MEDICINE USE ONLY

Date request received: _____ Date accounting sent: _____

Extension requested ___ No; ___ Yes – Reason: _____

Request Processed By: _____

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