UF UNIVERSITY of FLORIDA

REQUEST FOR ACCOUNTING OF DISCLOSURES

Patient Name	Medical Record Number
Address to which response should be sent:	Telephone # (optional)
Verification of Identity	Date of Birth

** Complete the following only if the person making the request is not the patient:

Name of Requestor	Relationship to Patient or Legal Authority
Verification of Identity	Verification of Authority

REQUEST

Please provide an accounting of all disclosures related to the above patient's health information, that were not related to treatment, payment, or health care operations, and were not authorized by the patient or the patient's legal representative, for the following dates:

From: _____ To: _____

Please Note: The maximum time frame cannot be more than six years prior to the date of your request.

FEES – choose one and initial both spaces.

A	____ This is my first accounting request in the current 12-month period. ____ I understand that there is no fee for this request, but a fee will be charged if I make other accounting requests within the next 12 months.
B	____ There has already been at least one accounting request during the current 12-month period. ____ The fee for this request is $_____ and I wish to proceed. Date paid _____ Amount _____ Cash Check Credit Debit

_____ _____

Signature of Patient or Legal Representative Date

NOTE: The Accounting of Disclosures requested will be provided within 60 days unless there is an unforeseen delay, in which case you will be notified in writing that an extension is needed. Such extension will not exceed 30 days.

FOR OFFICE USE ONLY

Date request received: _____ Extension required: ____ Yes ____ No

If yes, give reason: _____

Patient notified of extension in writing (Date) _____ by (Name) _____

Date accounting sent: _____

Staff member processing request: _____

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