Yale University School of Nursing Form

Request for Accounting of Disclosures of Protected Health Information

I, _______________________________,
Print Name
request an accounting for disclosures of my health or billing information:

For the period: FROM:___________________ TO:_____________________/__/__
Name of Physician(s) seen: ____

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

- to those for whom use and disclosure of my health information was made to carry out my treatment, process payment for my health care, or carry out Yale's health care business operations
- to myself or my personal representative
- that are incidental disclosures made in connection with a use or disclosure otherwise permitted or required by HIPAA
- to persons involved in a 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

I understand that this accounting will include all disclosures of HIV-related information except those 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.

PATIENT NAME: ____
LAST FIRST MI

DATE OF BIRTH:____-____-____ MEDICAL RECORD: _________________________
MO DAY YR
ADDRESS:____________________________________CITY:_____________________STATE:____ZIP:_____

DAY PHONE:_________________________________ EVENING PHONE:_________________________

Signature: ____ Date:_________________________
If not signed by patient, indicate relationship to patient: ____

Send accounting to:

__________ the address indicated above

__________ Fax Number ____

__________ I will pick up the accounting in person. Please contact me at _______________________________

when the document (s) is/are ready.

Forward this Request To:

Yale School of Nursing Office of Clinical Affairs
100 Church St. South P.O. Box 9740
New Haven, CT 06536-9740
203-737-5700