

## ***Request for Accounting of Disclosures of Protected Health Information***

I, *(Please Print Name)* \_\_\_\_\_, request an accounting of disclosures of my health or billing information:

<b>For the Period:</b>	<b>From:</b> _____	<b>To:</b> _____
<b>Name of Physician(s) Seen:</b> _____		
_____		
_____		

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

- 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
- those that are 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
- those 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

**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.

**PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM**

# Request for Accounting of Disclosures of Protected Health Information

Name of Patient \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Medical Record # \_\_\_\_\_  
Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient Date OR Parent/Legal Guardian/Authorized Person Date

\_\_\_\_\_  
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 University Privacy Officer  
Yale University  
P.O. Box 208252  
New Haven, CT 06520-8252