UT Southwestern Medical Center

**Request for Accounting of Disclosures**

Pt. Name:_____
Address:_____
_____
City State Zip
MRN: _____
DOB: _____
SEX:_____
DOS: _____

You have the right to request that UT Southwestern Medical Center provide an accounting of certain disclosures of your protected health information. An accounting of disclosures may include disclosures up to 6 years prior to the date of the request. UT Southwestern Medical Center will respond to your request within 60 days of receipt of the request, unless you are notified in writing that a one-time extension of up to 30 days is needed. This does not include disclosures related to treatment, payment, healthcare operations or disclosures that you have authorized.

Please indicate the dates for which you are requesting an accounting of disclosures:

From:_____ [mo/date/year] To:_____ [mo/date/year]

Address to which the accounting will be mailed if different from above:

_____

_____

_____

There will be no fee charged for the first accounting of disclosures in any 12 month period. Any additional accountings will be subject to a fee, payable at the time of the request.

_____ _____ _____
Patient's Signature Time Date

_____
Print Patient's Name

_____ _____ _____
Legal Guardian or Patient Representative's Signature Time Date

_____
Print Legal Guardian's or Patient Representative's Name

_____
Describe Relationship to Patient if other than Self

**For Internal Use Only**

Date request received: _____

Date accounting sent: _____

Extension requested: _____ no _____ yes. If yes, give reason:_____

Individual notified in writing of extension on this date: _____

Name and title of staff member processing request: _____



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