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| ou-logo | **The University of Oklahoma**      |

**Request for Accounting of Disclosures—Health Sciences Center**

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| Last Name: |  | First: |  | Middle: |  |
| Other Names Used: |  | Date of Birth: |  |
| Address: |       | City: |       | State: |       | Zip: |       |
| Home Phone: | ( )       |  Alt. Phone: | ( )       |  Cell Phone: | ( )       |
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NOTICE TO PATIENT:

Your request for an Accounting of Disclosures of your protected health information is applicable **only** to the information maintained by providers of the University of Oklahoma Health Sciences Center. If you would like to request an Accounting of Disclosures of your protected health information from any other University entity, a separate request must be submitted to that University entity. **(This request is applicable only to records disclosed by the OU Health Sciences Center.)**

**REQUEST FOR ACCOUNTING OF DISCLOSURES:**

I request an Accounting of Disclosures of the protected health information in my designated record set covering the period from \_     \_\_\_to\_\_\_     \_\_\_ (not to exceed 6 years, nor be for disclosures prior to April 14, 2003) maintained or created by the following providers of the University of Oklahoma Health Sciences Center.

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| **Name of Physician or Other Provider** | **Department/ Clinic** |
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I understand that the first accounting in a 12-month period is free of charge, but I can be charged a reasonable fee for any additional accountings during that period. I will be notified of any charge in advance.

**I understand that the accounting must include all disclosures, except for disclosures**

1. to carry out treatment, payment, or health care operations;
2. to individuals of protected health information about them;
3. incident to a use or disclosure permitted by the Privacy regulations;
4. pursuant to the individual’s Authorization;
5. to persons involved in the individual’s care or for a facility directory;
6. for national security or intelligence purposes;
7. to correctional institutions or law enforcement officials to provide them with information about a person in their custody;
8. as part of a limited data set; or
9. that occurred prior to April 14, 2003

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| Signature | Title, if Legal Representative\* | Date |

\*May be requested to show proof of representative status.

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129