THE UNIVERSITY OF ARIZONA

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION FORM

_____ _____ / _____ / _____
Name (Please print) Date of Birth (MM/DD/YY)

(_____)_____ _____
Phone Number E-mail Address

_____
Street Address

_____
City / State / Zip

_____
Name of the University of Arizona Department or Clinic

I request an accounting of disclosures of my protected health information (PHI) made by The University of Arizona (UA) department, clinic or other health care component named above to include disclosures made between the following dates:
_____ and _____ (no earlier than six (6) years prior to the date of this request).
(MM/DD/YYY) (MM/DD/YYY)

I understand that UA has sixty (60) days to comply with this request. UA may extend this time period by an additional thirty (30) days if I am provided with the reasons for the delay within the initial sixty (60) day time period. I understand that this list is free one (1) time in any 12-month period. A fee may be charged for additional lists in the same 12-month period.

The accounting I receive will NOT contain disclosures:

- To carry out Treatment, Payment, or Healthcare Operations;
- Pursuant to my authorization;
- Made to me;
- For the facility's directory
- To persons involved in my care or other notification purposes;
- Incidental to a permissible use or disclosure;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officials;
- As part of a limited data set;
- De-identified data;
- That occurred before April 14, 2003; or
- That occurred prior to six years before the date of this request.

Please continue to Page 2.

HPP Use Only:
HIPAA Privacy Program
v. 2015

SIGNATURE: _____ *DATE:* _____

Description of Authority to sign if personal/legal representative:

_____

IDENTITY OF REQUESTOR VERIFIED VIA: □ *Photo ID* □ *Matching signature* □ *Other:* _____