THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Health information Management
Phone Number (419) 383-4982
Fax Number (419) 383-3001

Mailing Address: **Health Information Mgmt- Release of Information**
University of Toledo Medical Center
1015 Research Drive, Toledo, OH 43614

REQUEST FOR AN ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

Date of Request: ____________

Patient Name _________________________________ **DOB**____________ **Medical Record #** ___________ **SS#** _____________ **Phone #** ___________________ **Address** ______________________________________ ______________________________________ ______________________________________	**Recipient Address:** ________________________________ ________________________________ ________________________________ ________________________________

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Dates Requested:
I would like an accounting of all disclosures for the following time frame. (Please note: There is no tracking of disclosures prior to April 14, 2003.) This accounting will cover all release of protected health information other than that which was done for treatment, payment or hospital operations.

From: _____________To: ____________

FEES:
First request in a 12-month period: Free
Subsequent Requests: $15.00 per request The fee for this request will be: _______

I understand that there is a fee for this accounting and wish to proceed. I also understand that my request for an accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

____
Name of Requestor

_________________________________ _________
Signature of Patient or Legal Representative Date

____
Relation to the Patient if other than the Patient

For UTMC Use Only:

Date Received: ___________ **Date Sent:** ___________ **Staff Member Processing Request:** _______

Extension Requested: ___NO ____Yes-Reason______________________

Patient notified of extension in writing on this date: _____________