University Health System
Surgery Center – Robert B. Green Campus
Surgery Center – Medical Center

4502 Medical Drive
Medical Records Department, MS# 26-2
San Antonio, Texas 78229-4493

Phone (210) 358-3532 Fax (210) 358-5936

Request for an Accounting of Disclosures

Patient's Name: ____
Last First Middle

Address: ____
Street City State Zip

Phone: (____)________________ **Date of Birth:** ______________ **MRN:** ________________________

Address to send disclosure to (if different than above):

____
Street **City** **State** **Zip**

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. **Please Note: the maximum time frame that can be requested is six years prior to the date of request.**

From: ____ **To:** ________________________________

FEES

There is no charge for the first accounting of disclosures request in a 12-month period. For subsequent requests in the same 12-month period, the amount is $ 25.00.

I understand that there is (check one)

________ No fee for this request ______The fee for this request is specified above and I wish to proceed

RESPONSE TIME

I understand the accounting of disclosures I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

____ ____________________

Signature of Patient or Patient's Representative Date

FOR UNIVERSITY HEALTH SYSTEM USE ONLY **DATE RECEIVED**____________________

DATE ACCOUNTING OF DISCLOSURES MAILED: ________________________

EXTENSION REQUESTED: _____ **NO** ______ **YES, REASON:** ____

____

PATIENT NOTIFIED IN WRITING ON THIS DATE: ________________________

____

SIGNATURE OF ROI STAFF/HIM