



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

Phone (210) 358-3532

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### 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 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**

