University Health System

4502 Medical Drive
Medical Records Department, MS# 26-2
Phone (210) 358-3532 San Antonio, Texas 78229-4493 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