UNIVERSITY OF UTAH HEALTH CARE

PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

Name of Patient _____ **Date of Birth** _____

Medical Record #_____ **Phone #** _____

Patient Address _____

_____

Patient Email Address _____

I request the University of Utah Health Sciences (UUHS) provide me with an accounting of disclosures of my protected health information between _____ (beginning date) and _____ (ending date).

I understand that my accounting of disclosures will NOT include disclosures:

- for treatment, payment, health care operations, or most uses within the Health Sciences;
- made with my authorization;
- made as part of a limited data set;
- that are restricted by a law enforcement official or public health agency; or
- made prior to April 14, 2003.

I understand that I may be charged for this information if I have previously requested this information within the previous 12 months. I have been informed of the approximate cost of **$**_____ and agree to be financially responsible for this charge.

_____
Signature of Patient or Representative Date

_____
If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority

- ☐ Parent
- ☐ Foster Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other, Explain, attach: _____

_____

Patients: Bring this form to Health Information, or mail to: Health Information, 50 N. Medical Dr., Salt Lake City, UT 84132

A notarized signature is required unless the patient or personal representative's ID is verified by UUHS staff.

SUBSCRIBED AND SWORN before me this ____ day of _____, 20____.

_____
NOTARY PUBLIC

Residing in _____

My Commission expires: _____