(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

Request for an Accounting of Disclosures

Date of Request: ____________________

Patient Name: ____

Date of Birth: ________________ **Medical Record Number:** ____________________

Patient Address: ____

____

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

____

____

Dates Requested:

I would like an accounting of disclosures for the following time frame:
(Please note: an accounting can only go back six years from today's date.)

From: _____/_____/_____ To: _____/_____/_____

Fees:

The first request in a 12-month period is free.
There may be a charge for subsequent requests in that same 12-month period.

The fee for this request will be: __________

I understand that there may be a fee for this accounting, and I wish to proceed with my request. I also understand that the 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.

______________________________ ____________ ____________

Signature of Patient or Legal Representative Date Time

If Legal Representative, authority of Legal Representative ____________________
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

For Healthcare Organization Use Only:

Date Received: ____________________ Date Accounting Sent: ____________________

Extension Requested: No _____ Yes _____ Reason: ____________________

Patient notified in writing on this date: ____________________

Staff Member Processing Request: ____________________

Med Rec 2323 (11/10)
HIPAA