## **UV** DUKE UNIVERSITY HEALTH SYSTEM REQUEST FOR AN ACCOUNTING OF DISCLOSURES

DATE OF REQUEST:	MEDICAL RECORD #:
PATIENT NAME:	DOB:
PATIENT ADDRESS:	

ADDRESS TO SEND DISCLOSURE ACCOUNTING (if different from above):

I would like to receive an accounting of all disclosures of my health information for the following time frame:

(Please note: the maximum time frame that can be requested is six years prior to the date of the request, but not before 04/14/2003).

## DATES REQUESTED:

From:		То:
Fees:	First request in twelve month period:	Free
	Subsequent Requests:	\$ 15.00

I understand that there is a fee for this accounting (if applicable) and wish to proceed. 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		
MAIL COMPLETED FORM TO:	DUHS Privacy Office Box 3162 Durham, NC 27710			
For DUHS Privacy Office Use Only:				
Date Received:	Date Sent: _			
Extension Requested:  No  Yes, Reason:				
Patient notified in writing on this date: Copy of Verification of Identity of patient and/or legal representative obtained/filed: D				
Staff member processing request:				