Policy (CS 30) Individual Request for Accounting of Disclosures of Protected Health Information

SECTION I:

Patient/Individual Name: _____

Patient/Individual Date of Birth: _____

Patient Individual Medical Record Number_____ OR SSN (Last 4 Digits) _____

Patient Individual Address: _____

_____

SECTION II:

I am requesting an accounting of disclosures of my protected health information from:

School/Department/Unit: _____

For the Period: From: _____ To: _____

Accounting should be sent to: ☐ Address Above

☐ Different Address: _____

_____

☐ Email Address: _____

SECTION III:

- I understand that the accounting will be provided to me within 60 days of my request unless I am notified in writing that an extension of up to 30 days is needed.
- I understand that the following disclosures are excluded from tracking and will not be included in the accounting:
    - Disclosures made for treatment, hospital payment, and healthcare operations
    - Disclosures to the patient
    - Disclosures made pursuant to a valid authorization
    - Disclosures made for facility directory purposes
    - Disclosures made to persons involved in the patient's care
    - Disclosures made for national security or intelligence purposes, to correctional facilities or law enforcement
    - Disclosures made as part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health, or certain healthcare operations purposes
- I understand that the University is not required to track disclosures made prior to the implementation of the Health Insurance Portability and Accountability Act (HIPAA) and is only required to maintain disclosures for a period of six (6) years prior to the date of my request
- I understand that I am permitted one free account of disclosures per 12-month period and that there will be a flat fee charged for additional or subsequent requests made within that 12-month period. I understand I will be afforded the opportunity to withdraw or modify my request to avoid or reduce the fee.

Signature of Individual/Representative: _____

Representative Relationship to Individual: _____ Date: _____

UNIVERSITY OF PITTSBURGH INTERNAL USE ONLY

Date Received: _____

Received and Processed by:

Name: _____ Title/Position: _____

Covered Component: _____

Extension Requested: Y/N Length of Extension (not to exceed 30 days): _____

Requestor notified in writing: Y/N Requestor notified in writing as of: _____

Reason for Extension Request: _____

_____

Accounting of Disclosure sent: No Date Sent: _____

Business Associates contacted (if applicable): _____

*For individuals requesting accounting of disclosures from multiple schools/departments/units, please document date(s) request(s) forwarded to other facilities:

_____

_____

Signature of Authorized Component Employee: _____

Date: _____