Patient Request for Accounting of Disclosures
UNC Health Care System

Name of Patient:_____ Medical Record #: _____

Date of Birth: _____ Phone #: _____

Patient Address: _____

Social Security Number (Optional): _____

I request UNC Health Care System provide me with an accounting of any and all applicable disclosures of my protected health information between _____ (beginning date) and _____ (ending date).

I understand that my accounting of disclosures will not include disclosures made under certain circumstances: treatment, payment, or health care operations, pursuant to your authorization, as part of a limited data set, or disclosures made prior to April 14, 2003.

I understand the accounting of disclosures will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

I understand that I may be charged for this information if I have previously requested this information within the last 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

_____ _____
Name of Representative (if applicable) Relationship to Patient

Address to Send Accounting to:

☐ Send accounting to the above address

☐ Send accounting to the following address: _____

INTERNAL USE ONLY

Date Received:_____ Date Sent: _____

Extension Requested: ☐ Yes ☐ No

Reason for Extension: _____

_____

Other Comments: _____

_____

Signature/Title of Staff Member: _____ Date: _____