Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd.
Mail Code: OP17A
Portland, Or 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Stamp Patient Card Here

REQUEST FOR ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION

SECTION A: Individual to complete the following. (Please print)

NAME _____
Last First Middle

ADDRESS _____

TELEPHONE NO. _____ BIRTH DATE _____

MEDICAL RECORD NO. _____ SOCIAL SECURITY NO. _____
(If applicable) (Optional)

REQUEST:

I hereby request an accounting of disclosures of my health information as follows **(CHECK ONE):**

- ❑ For all disclosures, subject to HIPAA* accounting requirements, made during the six (6) year period prior to the date of this request, but not including disclosures made before April 14, 2003.
- ❑ For all disclosures, subject to HIPAA accounting requirements made during the following time period: _____ through _____ (not to include disclosures made before April 14, 2003).

I understand that the first accounting in any twelve (12) month period, will be provided to me at no cost. For any additional accounting requested within the same twelve (12) month period, OHSU may charge a reasonable fee.

Date: _____

Signature of Individual or Legal Representative _____

Print Name of Legal Representative (If Applicable) _____

Legal Representative's Relationship to Individual (If Applicable) _____

* HIPAA means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

MR1449

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SECTION B: OHSU to complete the following.

DATE REQUEST RECEIVED FROM INDIVIDUAL _____

PERSON RECEIVING REQUEST _____

DATE ACCOUNTING SENT TO INDIVIDUAL _____

PERSON SENDING ACCOUNTING _____

METHOD BY WHICH ACCOUNTING WAS DELIVERED:
☐ Mail ☐ In-person ☐ Electronic means ☐ Other _____

Staff comments _____

Signature of Staff Member _____

Print Name and Title _____

Department/Area _____