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: _____ To: _____

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: ☐

Staff member processing request: _____