



THE UNIVERSITY OF TOLEDO  
**MEDICAL CENTER**

**Health information Management**  
**Phone Number (419) 383-4982**  
**Fax Number (419) 383-3001**

**Mailing Address:** **Health Information Mgmt- Release of Information**  
**University of Toledo Medical Center**  
**1015 Research Drive, Toledo, OH 43614**

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**REQUEST FOR AN ACCOUNTING OF PROTECTED HEALTH INFORMATION  
DISCLOSURES**

**Date of Request:** \_\_\_\_\_

<b>Patient Name</b> _____ <b>DOB</b> _____ <b>Medical Record #</b> _____ <b>SS#</b> _____ <b>Phone #</b> _____ <b>Address</b> _____ _____ _____	<b>Recipient Address:</b> _____ _____ _____ _____
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**Dates Requested:**

I would like an accounting of all disclosures for the following time frame. (Please note: There is no tracking of disclosures prior to April 14, 2003.) This accounting will cover all release of protected health information other than that which was done for treatment, payment or hospital operations.

**From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**FEES:**

**First request in a 12-month period: Free**

**Subsequent Requests: \$15.00 per request The fee for this request will be:** \_\_\_\_\_

I understand that there is a fee for this accounting and wish to proceed. I also understand that my request for an 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.

\_\_\_\_\_  
Name of Requestor

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation to the Patient if other than the Patient

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*For UTMC Use Only:*

**Date Received:** \_\_\_\_\_ **Date Sent:** \_\_\_\_\_ **Staff Member Processing Request:** \_\_\_\_\_

**Extension Requested:** \_\_\_NO \_\_\_Yes-Reason\_\_\_\_\_

**Patient notified of extension in writing on this date:** \_\_\_\_\_