

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

Dates Requested:	Patient Name		Recipient Address:
Dates Requested: would like an accounting of all disclosures for the following time frame. (Please note: Maximum 6 years prior to date of request.) This accounting will cover all release of protected health information other than that which was done for treatmer payment, operations or excused by law. FEES: First request in a 12-month period: Free Subsequent Requests: \$15.00 per request The fee for this request will be: 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 Date Date	DOB	Medical Record #	
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	Signature of Paragrams Relation to the For UTMC Use Contact Received:	Patient of Legal Representative Patient if other than the Patient Only:	Staff Member Processing Request:

Patient notified of extension in writing on this date: