



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

REQUEST FOR AN ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

Date of Request: _____

Patient Name _____ DOB _____ Medical Record # _____ SS# _____ Phone # _____ Address _____ _____ _____	Recipient Address: _____ _____ _____ _____
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Dates Requested:

I 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 treatment, 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: _____

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

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: _____