

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label



**PATIENT REQUEST FOR
ACCOUNTING OF DISCLOSURES**

Patient Rights-P
HIPAA Privacy Patient Rights



IDN13150017

INSTRUCTIONS: You have the right to an accounting of the disclosures of your protected health information for instances not related to treatment, payment, or healthcare operations. When making this request, please use this form or the e-form available on MyChart.

Patient Information – please provide us with the following information about the patient:

Last Name First Name Middle Name

Street Address City State

Zip Code XXX-XX- Last 4 SSN Date of Birth

Patient Signature Date of Request Phone Number

Personal Representative – if you are the patient's personal representative, please provide your information below:

(Note: If a personal representative is making this request, please attach certifying documentation of your status as the personal representative, such as a Power of Attorney or Guardianship papers).

Last Name First Name Middle Name

Personal Representative Signature Date of Request Relationship to Patient

I request an accounting of disclosures of my health information that were made during the following time frame:

from ____ / ____ / ____ **to** ____ / ____ / ____ .

(Please note: requests are limited to the immediate six (6) year period prior to the date of request).

If you would like to request an audit of access to your medical record,
please contact the Privacy Office at (312) 942-5303 or privacy_office@rush.edu

When completed, please return this form to:

Rush, ATTN: Privacy Office, 707 South Wood St., Suite 317, Chicago, IL 60612-3833
Telephone: (312) 942-5303 • Fax: (312) 942-6875