Patient Name: _____

Date of Birth: _____

Medical Record#: _____

Place Patient Label

RUSH
Rush Copley Medical Center

PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

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	X X X – X X - 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

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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

 INTERPRETER ATTESTATION: Interpretation has been provided by _____ □ Phone