SOUTHEAST MISSOURI STATE UNIVERSITY

Please check the appropriate Health Care Component

❐Self-funded Health Plan ❐Health Clinic ❐Autism Center

REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

I, ____________________________, hereby request an accounting of all of the disclosures of my protected health information made by Southeast Missouri State University Health Care Component indicated above (the "Covered Entity").

Please account for all disclosures made from __________________, 20___, to _________ ____________, 20___ (note that this period may not exceed six (6) years for paper records or three (3) years for disclosures to carry out treatment, payment and health care operations documented in an electronic health record (EHR) and cannot include disclosures made prior to April 14, 2003).

Please provide this accounting in the following format (i.e., electronic, hard copy, etc.): ____.

Please send this accounting to the following address:

____

I acknowledge that there will be a charge for this accounting if I have requested an accounting within the last twelve (12) months. I will be notified in advance of the fee associated with this accounting and will be given the opportunity to modify or withdraw my request in order to reduce or avoid this charge.

___________________ ____

Dated Signature of Patient or Representative

____

Description of Representative's Authority

____

FOR OFFICE USE ONLY

Request received on: _________________________.
Accounting provided on: _______________________.
Charge for accounting: _________________________.

____________ _____________________________________

Dated Signature