

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