PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

You have a right to request an "accounting of disclosures" which provides information about certain ways we have disclosed your health information to persons or organizations outside of the hospital. Please see our Notice of Privacy Practices for a more detailed description of your rights to request this accounting and the process we follow once we have received your request. If you would like to request an accounting of disclosures after reading this information in our Notice of Privacy Practices, please complete and return the form below.[1]

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First MI

Address: _____

Telephone: _____ _____
Daytime Evening

Email Address (Optional): _____

1 A covered entity may find it helpful to attach a tracking label or number to this form so that Records Department staff will be able to identify the recipient in the event that the patient returns a form with the patient's name incomplete or illegible.

PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

REQUEST FOR ACCOUNTING

I would like an accounting of all disclosures made during the following period of time:

(MM/DD/YYYY) FROM: _____ / _____ / _____ TO: _____ / _____ / _____

Please note that we cannot provide accountings of disclosures that were made more than six years ago or before April 14, 2003.

POSSIBLE FEES

You are entitled to one free accounting every 12 months. If you have already requested an accounting within the last twelve months, we may charge a reasonable fee to cover the costs of producing any additional accounting you are requesting on this form. We will notify you before any fee is charged, so that you may decide whether to continue with your request, modify your request to reduce the fee, or withdraw your request and pay no fee.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that HSS provide me with the accounting described above. I understand that I will be contacted if any fee will be charged for providing this accounting and that I will have an opportunity to modify or withdraw my request if I do not want to pay that fee.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date / Time

_____

Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

Health Information Management
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Or

Email to: ROIrequest@hss.edu

Or

Fax to 212-774-7364

FOR [HOSPITAL] USE ONLY:

Date Received: (MM/DD/YYYY) _____ / _____ / _____

Date Request Was Fulfilled/Completed: (MM/DD/YYYY) _____ / _____ / _____

Fee Charged For Fulfilling This Request (if applicable): $ _____

Name of Records Department Staff Member Processing This Request: _____