(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

Request for an Accounting of Disclosures

Date of Request: _____

Patient Name: _____

Date of Birth: _____ **Medical Record Number:** _____

Patient Address: _____

_____

Address to send accounting of disclosure (if different than above):

_____

_____

Dates Requested:

I would like an accounting of disclosures for the following time frame:
(Please note: an accounting can only go back six years from today's date.)

From: _____/_____/_____ To: _____/_____/_____

Fees:

The first request in a 12-month period is free.
There may be a charge for subsequent requests in that same 12-month period.

The fee for this request will be: _____

I understand that there may be a fee for this accounting, and I wish to proceed with my request. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

_____ _____ _____
Signature of Patient or Legal Representative Date Time

If Legal Representative, authority of Legal Representative: _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

For Healthcare Organization Use Only:

Date Received: _____ Date Accounting Sent: _____

Extension Requested: No ____ Yes ____ Reason: _____

Patient notified in writing on this date: _____

Staff Member Processing Request: _____