REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

Date: _____   Name: _____

SID, if applicable: _____   Date of Birth:_____

I would like an accounting of how my Protected Health Information was disclosed by UHS, as allowed by federal regulations.

I understand that UHS does not have to tell me about disclosures:
- For purposes of treatment, payment and health care operations or as part of a limited data set.
- Authorized by me or to me.
- To persons involved in my care (to notify a family member, personal representative or other person of the individual's location or general condition).
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials.
- Incidental to a use or disclosure otherwise permitted or required by law.

I also understand that the government, under limited circumstances, may suspend my right to an accounting of some or all disclosures.

I want an accounting of disclosures that covers the following time period:

From: _____   To: _____
         (date)   (date)
Note: the time period must be no longer than six years and prior to the date of the signed request

Please mark below if you wish to also include accounting of your Counseling and Psychological Services (CAPS) and/or Social Services records.
- ☐ Include accounting of CAPS records.
- ☐ Include accounting of Social Services records.

Please mail the accounting of disclosures to the following address:_____

_____

I understand that the UHS must give me the accounting of disclosures within 60 days, or tell me that it needs an extra 30 days (or less) to prepare it.

I am entitled to one free accounting of disclosures in any 12-month period. Additional accountings may have a charge associated with it.

If you believe your privacy rights may have been violated, you may file a complaint with the University Health Services. To file a complaint with UHS, please write the Privacy Officer, UHS, 2222 Bancroft Way, Berkeley, CA 94720-4300. **You will not be penalized for filing a complaint**.

Signature of patient   If representative,
or representative: _____   give relationship: _____