

**TULANE UNIVERSITY MEDICAL GROUP  
REQUEST FOR AN ACCOUNTING OF DISCLOSURES**

**1. PATIENT INFORMATION**

|  |  |
|--|--|
| <b>Date of Request:</b>  | <b>Medical Record or Billing Number:</b> |
| <b>Name:</b>   | <b>Date of Birth:</b>                    |
| <b>Social Security Number:</b>   | <b>Telephone Number:</b>                 |
| <b>Address:</b>  |  |
|  |  |
| <b>Address to send Accounting of Disclosure (if different than above):</b> |  |

**2. DATES REQUESTED**

I would like an accounting of all disclosures for the following time frame. *Please note:* the maximum time frame that can be requested is six years prior to the date of your request, and we are not required to account for disclosures that occurred before April 14, 2003.

From: \_\_\_\_\_ To: \_\_\_\_\_

**3. FEES**

There is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is \$25.00. I understand that there is (check one):

- No fee for this request.
- A fee for this request in the amount of \$25.00, and I wish to proceed.

**4. RESPONSE TIME**

I understand that the accounting I have requested 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 \_\_\_\_\_

**5. THIS SECTION FOR HEALTH CARE ORGANIZATION USE ONLY**

|   |                             |
|---|-----------------------------|
| Date request received: _____  | Date accounting sent: _____ |
| Requestor verified by which method? _____                                     |                             |
| Extension requested: <input type="checkbox"/> no <input type="checkbox"/> yes |                             |
| If yes, give reason: _____  |                             |
| Patient notified in writing on this date: _____                               |                             |
| Staff member processing request: _____  |                             |

\*\*This completed form will be permanently maintained with the permanent medical or billing or Privacy Official record\*\*

\*\* You have a right to receive a copy of this form after you have signed it\*\*