

# UCLA HEALTHCARE

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## REQUEST FOR AN ACCOUNTING OF DISCLOSURES

NAME: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

I would like an accounting of how my protected health information was disclosed by UCLA Healthcare, as required by federal regulations. I understand that UCLA Healthcare does not have to tell me about the following type of disclosures:

- Disclosures for purposes of treatment, payment, and healthcare operations
- Disclosures to me or authorized by me
- Disclosures for use in the hospital's directory (if I was admitted as an inpatient)
- Disclosures to persons involved in my care
- For national security or intelligence purposes
- To correctional institutions
- Disclosures made prior to April 14, 2003
- Disclosures incident to a use or disclosure otherwise permitted or required by federal law

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

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

\_\_\_\_\_

I want the accounting of disclosures in the following form:

- On paper  Electronically
- Please send my accounting to the following address: \_\_\_\_\_
- \_\_\_\_\_
- I want to pick up the accounting. Please call me the following phone number when it is ready: \_\_\_\_\_

I understand that UCLA Healthcare must give me the accounting of disclosures within 60 days, or tell me that an extra 30 days (or less) is needed to prepare it. I am entitled to a free accounting of disclosures in any 12 month period. Additional accountings will cost: \$ \_\_\_\_\_ each.

\_\_\_\_\_  
Signature of patient or representative

\_\_\_\_\_  
Date

Relationship to patient (if representative): \_\_\_\_\_

***(Forward to the HIMS/Privacy Management Office, UCLA Healthcare, Attention HIMS Director, 10833 Le Conte Avenue, Room CHS BH-921 Los Angeles, Ca 90095-7305)***