University Hospital
University of Missouri Health System

University of Missouri Health Care
Health Information Services
One Hospital Drive, DC042.00
Columbia, Missouri 65212
Phone (573) 882-3170

Request for an Accounting of Disclosures

Date of Request: _____ MRN: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street City, State Zip Code

Phone Number: _____

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

Street City, State Zip Code

Dates Requested:

I would like an accounting for disclosures for the following time frame: (please note that the maximum time frame that can be requested is six years prior to the date of the request).

From Date: _____ To Date: _____

I understand that the accounting of disclosures report will consist of those individuals that accessed your record for reasons other than treatment, payment, and healthcare operations. The accounting will not include a complete listing of every access made.

I 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[1] Date

[1]If signed by the legal representative, he or she should describe the nature of his or her authority to sign for the patient and attach a copy of the documentation.

Patient is: ☐ Minor ☐ Deceased ☐ Incompetent
Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Conservator
☐ Power of Attorney
☐ Other: _____