NYU Langone Health

## Patient Request for an Accounting of Disclosures

The Health Insurance Portability and Accountability Act ("HIPAA") gives you the right to receive an accounting of certain disclosures of your health information that are made by NYU Langone Health and its Business Associates for up to six (6) years prior to the date of your request. You are not entitled to receive an accounting of disclosures that are made to carry out treatment, to obtain or make payment for treatment, or for health care operations. You are not entitled to receive an accounting of disclosures that are made to you or pursuant to your authorization, to your family or other persons involved in your care, for national security, or certain law enforcement purposes.

You are entitled to one free accounting every 12 months. If you have already requested an accounting within the last 12 months, we will charge you a reasonable, cost based fee to cover the costs of producing an additional accounting. You will be notified of any fee in advance. You will receive the accounting via certified mail within 60 days of receipt of your request.

To request an accounting of disclosures, please complete the form below and send to: Privacy Officer, NYU Langone Health, One Park Avenue, 3rd Floor, New York, NY 10016.

**Patient Name** (please print): _____ **Date of Birth:**_____

**Patient Address**:_____

**Phone Number**: _____ **Email**: _____

**I request an accounting of disclosures of my health information that were made during the following time frame: from ____/____/_____ to ____/____/_____.**

**I understand that I may be charged a reasonable, cost based fee if I have already received an accounting within the last 12 months and I agree to pay the fee.**

**Please send the accounting of disclosures to me at:** _____

_____

_____

**Signature**: _____ Date:_____ Time:_____ AM/PM

**(Patient or person authorized to sign)**

*If the person consenting is not the patient, please print name and type of authority to sign. Supporting documentation should be provided at the time of submission.*

Name/Authority: _____

*NYU Langone Health Use Only* MRN: _____ Received: _____