OFFICE OF
HIPAA COMPLIANCE
CENTRAL MICHIGAN UNIVERSITY

Request for Accounting of Disclosures of Protected Health Information

I understand that I have the right to an accounting of uses and disclosures of my protected health information for purposes other than treatment, payment and operations of CMU. I understand that CMU will maintain the record of any disclosure outside of treatment, payment and operations for six years. I understand that CMU will respond to this request with-in 30 days unless I receive notification in writing that it will take longer to fulfill my request. I also understand that a fee may be charged for more than one accounting in a 12-month period, but CMU will notify me in advance of such fee.

Name: ____ Date: _____________________________

Address: ____ Telephone: ________________________

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Please specify the time period for which you would like an accounting of disclosures of your PHI.

From (MM/DD/YYYY)_______________ To (MM/DD/YYYY)________________

Specify CMU Clinic you would like the accounting from:

☐Carls Center for Clinical Care and Education

☐Injury Care Center

☐Athletics Sports Medicine

☐University Health Services

☐ Center for Community Counseling and Development

☐Other: _________________________

_________________________ ____________

Client/Patient/Employee Signature Date

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Guardian Signature, if appropriate

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Relationship to Client

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(For office use only)

Date Disclosure of Accounting is released: _________________

HIPAA Privacy Officer Signature:___________________________ Date: ____________________

Revised 10/31/25