



**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 the covered entity's operations. I understand that CMU's responsibility for such accounting became effective April 14, 2003, for the Psychological Training & Consultation Center effective July 1, 2004, and for the Physical Therapy Clinic on April 1, 2005, and that accounting for disclosures prior to that date is not available. I understand that CMU will maintain the record of any disclosure for six years. I understand that CMU will respond to this request in fewer than 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.*

Client/Patient/Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

*(Please Print Clearly.)*

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Please specify the time period for which you would like an accounting of disclosures of your PHI. Please specify the health care component. (No accounting is available prior to April 14, 2003 for Psychological Training & Consultation Center prior to July 1, 2004), or for the Physical Therapy Clinic before April 1, 2005.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client/Patient/Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature, if appropriate

\_\_\_\_\_  
Relationship to Client

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*(For office use only)*

Date Disclosure of Accounting is released: \_\_\_\_\_

Privacy Officer Signature: \_\_\_\_\_

Date: \_\_\_\_\_