Oregon Health & Science University
Hospitals and Clinics
Information Privacy and Security Office
3181 SW Sam Jackson Park Rd.
Mail Code: ITG09
Portland, OR 97239-3098
(503) 494-0219, Fax (503) 494-4828
Email oips@ohsu.edu

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

REQUEST FOR ACCOUNTING OF DISCLOSURES OF HEALTH INFORMATION

SECTION A: Individual to complete the following. (Please print)

NAME ____
Last First Middle

ADDRESS ____

TELEPHONE NO. ____________________ BIRTH DATE ____________________

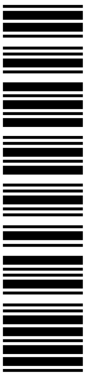
MEDICAL RECORD NO. ____________________ SOCIAL SECURITY NO. ____________________
(If applicable) (Optional)

REQUEST:

I hereby request an accounting of disclosures of my health information as follows **(CHECK ONE):**

- ❑ For all disclosures, subject to HIPAA* accounting requirements, made during the six (6) year period prior to the date of this request, but not including disclosures made before April 14, 2003.
- ❑ For all disclosures, subject to HIPAA accounting requirements made during the following time period: ______________ through ______________ (not to include disclosures made before April 14, 2003).

I understand that the first accounting in any twelve (12) month period, will be provided to me at no cost. For any additional accounting requested within the same twelve (12) month period, OHSU may charge a reasonable fee.



Date: ____________________ **Time:** ______________

Signature of Individual or Legal Representative ______________________________

Print Name of Legal Representative (If Applicable) ______________________________

Legal Representative's Relationship to Individual (If Applicable) ______________________________

* HIPAA means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

MR1449

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ACCOUNT NO.
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SECTION B: OHSU to complete the following.

DATE REQUEST RECEIVED FROM INDIVIDUAL ______________________________

PERSON RECEIVING REQUEST ______________________________

DATE ACCOUNTING SENT TO INDIVIDUAL ______________________________

PERSON SENDING ACCOUNTING ______________________________

METHOD BY WHICH ACCOUNTING WAS DELIVERED:
☐ Mail ☐ In-person ☐ Electronic means ☐ Other ______________________________

Staff comments ______________________________

Signature of Staff Member ______________________________ Date: __________ Time: __________

Print Name and Title ______________________________

Department/Area ______________________________

Document Information

Document Title

HIPAA - Request for Accounting of Disclosures of Health Information (MR-4644)

Document Description

N/A

Approval Information

Approved On:	12/03/2018
Approved By:	Dot Maddoux
Approval Expires:	12/03/2023
Document Location:	/ Medical Record Forms / HIPAA & other authorization forms
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