uchealth

Request for an Accounting of Disclosures of Protected Health Information

Name of patient ______________________________

Patient's date of birth ______________________________

Date of request ______________________________

Name of person making request if other than patient ______________________________

Time period of disclosures for which I am requesting an accounting:

(The list we provide will include disclosures made within the last 6 years, unless you specify a shorter period.)

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Information about your rights to receive an accounting

You have the right to get a list of instances we have disclosed your health information. The list will not include certain disclosures including, but not limited to, those we have made for our treatment, payment and health care operations purposes, those made directly to you or to your family or friends or through our facility directory, or for disaster relief purposes. Nor will the list include disclosures we have made for national security purposes, to law enforcement personnel with your written authorization, or disclosures made before April 14, 2003.

We will respond to your request for an accounting within 60 days of receipt of this request (or 90 days if extra time is needed).

Charges for accounting

The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period. In order to avoid or reduce the fee, you have the right to withdraw or modify your request by writing to us.

By submitting this form, I hereby request UCHealth to provide me with an accounting of disclosures of my health information made by UCHealth.

______________________________ ______________________________

Name of patient or legally authorized representative (printed) Relationship to patient

______________________________ ______________________________

Signature of patient or legally authorized representative Date Time

CERTIFICATION OF INTERPRETER SERVICES

Provider must check mark this section if an interpreter is used to be a valid consent.

☐ Certification of Interpreter Services (if the patient's preferred language for health care is not English). I have communicated the information on this form and any explanations to the patient using a qualified Medical Interpreter in the patient's preferred language, or by speaking to the patient as a Qualified Bilingual Provider.

Please mail this form to:

UCHealth
Attn: Health Information Management Department
1400 E. Boulder St.
Colorado Springs, CO 80909

Or email it to:

AODRequests@UCHealth.org

Name of UCHealth staff who received form ______________________________ Date/time form received ______________________________

uchealth

Solicitud de un informe sobre las divulgaciones de información médica protegida

(Request for an Accounting of Disclosures of Protected Health Information)

Nombre del paciente ______________________________

Fecha de nacimiento del paciente ______________________________

Fecha de la solicitud ______________________________

Solicito un informe de las divulgaciones realizadas durante el siguiente periodo de tiempo:

(Le proporcionaremos una lista de las divulgaciones realizadas en los últimos seis [6] años, a menos que haya indicado un periodo de tiempo más corto.)

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Información sobre su derecho a recibir un informe de divulgaciones

Tiene derecho a recibir una lista de ocasiones en las que divulgamos su información de salud. Esta lista no incluirá algunas divulgaciones, incluidas, pero no limitadas a, aquellas que se realizaron con fines de tratamiento, pago y operaciones de servicios de atención médica, divulgaciones hechas directamente a usted, su familia o amigos o a través del directorio de nuestras instalaciones, o con fines de ayuda en desastres. La lista tampoco incluirá divulgaciones hechas para fines de seguridad nacional, a agentes del orden público cuando usted haya dado su autorización por escrito, o divulgaciones hechas antes del 14 de abril de 2003.

Responderemos a su solicitud del informe dentro del plazo de 60 días después de recibirla (o 90 días si se requiere tiempo adicional).

Costos correspondientes al informe

La primera lista que solicite en un período de 12 meses es gratuito. Se le cobraran los gastos de preparación de cualquier informe adicional dentro del mismo período de 12 meses. A fin de evitar o reducir los costos, tiene derecho a retirar o modificar su solicitud informándonos por escrito.

Por medio de esta solicitud, autorizo a UCHealth a suministrarme un informe de las divulgaciones de mi información médica que haya realizado.

______________________________ ______________________________

Nombre del paciente o representante legal autorizado (en letra de molde) | Relación con el paciente

______________________________ ______________________________

Firma del paciente o representante legal autorizado | Fecha | Hora

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Envíe la solicitud a:

UCHealth
Atención: Kendra Adams
Health Information Management Department
Mailstop AO25
12401 E. 17th Ave.
Aurora, CO 80045

O por correo electrónico a:

AODRequests@UCHealth.org

Name of UCHealth staff who received form ______________________________ Date/time form received______________________________