



Medical Record #

**Request for Accounting of Disclosures**  
The University of Mississippi Medical Center (UMMC)

All requests are forwarded to the Office of Integrity and Compliance. In completing this form, you are requesting an accounting of all entities that obtained information unrelated to treatment, payment, or healthcare operations without your permission, except as otherwise required by law.

Forms that are not complete will not be accepted. Your request must state the time period desired for the accounting, which must be less than a six-year period and starting after April 14, 2003. If you make more than one request in the same year, you will be charged a fee based on the cost for each additional request.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Contact Phone Number(s)

\_\_\_\_\_  
Begin Date (mm/dd/yyyy)

\_\_\_\_\_  
End Date (mm/dd/yyyy)

**DISCLOSURES EXCLUDED FROM ACCOUNTING REQUIREMENTS**

Not all disclosures or protected health information must be included in the accounting. Federal regulations DO NOT require the following disclosures to be included in the accounting:

- Disclosures used to carry out treatment, payment, and healthcare operations;
- Disclosures made pursuant to an authorization signed by the individual or his/her representative;
- Disclosures of PHI about an individual made to the individual;
- Disclosures made through the facility directory;
- Disclosures made to persons involved in the individual's care;
- Disclosures made for notification purposes, such as to assist law enforcement in notifying family members of an individual brought to the ER from an accident scene;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials for individuals about the health of an inmate;
- Disclosures made prior to April 14, 2003 or more than six years prior to the request;
- Certain disclosures to health oversight agencies and law enforcement officials.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date of Request

\_\_\_\_\_  
Description of Personal Representative's Authority