



ACCOUNTING OF NON-AUTHORIZED USE OR DISCLOSURE REQUEST FORM

THIS FORM IS TO BE USED TO FILE AN OFFICIAL REQUEST FOR A COPY OF THE MEDICAL CHART'S DISCLOSURE LOG.

PATIENT IDENTIFICATION

Name: _____ Date of Birth: _____ SSN: _____
Address: _____ Phone: _____

PATIENT REQUEST

I, _____, request that the University of Central Florida Health Services provide me with an accounting of any and all applicable "non-authorized" uses and disclosures of my protected health information (PHI) between _____ and _____.

I would like to limit this request for accounting to include disclosures only pertaining to:

Patient Signature

Date

For Office Use Only

Privacy Officer Action: Actions must be taken within 60 days of the receipt of the request

Request approved

Request denied for the following reason: _____