Riverside University HEALTH SYSTEM Medical Center

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Once you have completed the entire form, please submit the form by any of the following options:

- **Email:** RUHS-ROI@ruhealth.org
- **Mail:** Riverside University Health System - Medical Center, Attn: Medical Records, 7898 Mission Grove Parkway South, Suite 200, Riverside, CA 92508
- **In Person:** Medical Records Department at Riverside University Health System - Medical Center.

Today's Date:	Patient Name:	Medical Record Number:	Date of Birth:
Address:		Phone:	

I request an accounting of how my protected health information was disclosed by **Riverside University Health System - Medical Center**, as required by federal regulations. I understand that the hospital does not have to tell me about the following types of disclosures:

1. Disclosures for purposes of treatment, payment, and health care operations or as part of a limited data set.
2. Disclosures to me or disclosures authorized by me.
3. Disclosures for use in the hospital's directory.
4. Disclosures to persons involved in my care.
5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).
6. For national security or intelligence purposes.
7. To correctional institutions or law enforcement officials
8. Disclosures incident to a use or disclosure otherwise permitted or required by federal law.

I also understand that my right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

➢ I want an accounting of disclosures from the following time period: _____
(Note: the time period must be no longer than six years)

➢ I am interested in the following specific disclosures: _____
(Note: This section does not have to be completed.)
_____

➢ I want the accounting of disclosures in the following form:
☐ Mail the accounting to the following address: _____
☐ Pick up the accounting. Please call me at the phone number listed above when it is ready.

I understand that the hospital must give me the accounting of disclosures within 60 days or tell me they need an extra 30 days (or less) to prepare it.

I am entitled to one free accounting of disclosures in any 12-month period. A fee may be charged for subsequent request one 12-month time period.

_____ _____
Signature of patient or legal representative: **Date &Time**

_____ _____ _____
Legal representative print name **Relationship to patient** **Legal rep. phone**

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For more information about your privacy rights, see the “Notice of Privacy Practices” available on our website at https://www.ruhealth.org/medical-center/patients-visitors/patient-rights or at **Health information Management Department** at **Riverside University Health System - Medical Center** or by sending a written request to Attn: Medical Records, 7898 Mission Grove Parkway South, Suite 200, Riverside, CA 92508.

If you believe your privacy rights have been violated, you may file a complaint with the Compliance Officer. To file a complaint with the hospital, contact the compliance Office (951) 486-4659. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**