US Radiology Specialists
Imaging and Interventional Partners

Request for an Accounting of Disclosures

Patient Information:

Name: ____ Date of Birth: __________________

Address: ____

____

Address to send disclosure accounting (if different from above):

____

____

Information Requested: Please note, the maximum time frame that can be requested is six years prior to the date of your request. The accounting will not include disclosures made for treatment, payment or healthcare operations, to persons involved in the patient's care, or pursuant to an authorized request from the patient.

1. I request an accounting of disclosures for: (check/complete a. or b.)	
	a. The time period from: ______________________ to: ________________________
	b. Six years prior to the request date.
2. I request an accounting of disclosures made to: (check/complete a. or b.)	
	a. The following persons or entities or for the following purposes:
	b. All recipients.

If requested by someone other than the patient, please provide the name of the requestor and relationship to patient:

____

Signed: ____ **Date**: _____________________

USRS does not charge for the first accounting request in a twelve-month period. For each additional request, USRS may charge a reasonable cost-based fee. You will be notified of any fee in advance and provided the opportunity to change your request. USRS will provide the accounting within sixty days unless an extension is required. If an extension is required, USRS will notify you in writing.

FOR USRS USE ONLY:

Dates:
Received: _____________ Reviewed by Compliance: ____________ Provided: _______________

If extension was required, provide the reason:____

____

____

Date requestor was notified, in writing, of need for extension: ______________________________

Employee who processed the request: ____

US Radiology Specialists
Imaging and Interventional Partners

Request for an Accounting of Disclosures

Protected Health Information Disclosure Log

Patient Name: ____ Date of Birth: ______________________

Date request received (if applicable)	Name of Requestor or Recipient	Method of Disclosure (include address, email or fax where sent)	Authorization Received?	Purpose of Disclosure (e.g., continuity of care, insurance processing, legal)	PHI Disclosed (be specific – e.g., name, DOB, treatment records from 01/01/19-06/30/19	Date Disclosed	Disclosed By