



Florida Atlantic University
Request for Accounting of Disclosures of Protected Health Information (PHI)

Your Rights

Under HIPAA, you have the right to request a list of certain disclosures of your Protected Health Information (PHI).

Use this form to make that request.

Section 1: Patient Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Street Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Email Address (optional): _____

Section 2: Request Details

Start Date (MM/DD/YYYY): _____

End Date (MM/DD/YYYY): _____

Note: Date range cannot exceed six (6) years and cannot be earlier than April 14, 2003.

Section 3: Delivery Method

Mail

Secure Email

Pick up in person

Section 4: Important Information

The first request within a 12-month period is free.



Additional requests may require a fee.

You will be notified of any fees before processing.

Section 5: Signature

Signature: _____

Date (MM/DD/YYYY): _____

Section 6: Personal Representative (if applicable)

Representative Name: _____

Relationship to Patient: _____

Authority to Act: _____

For Office Use Only

Date Request Received: _____

Received By: _____

Date Completed: _____

Method of Delivery: _____

Notes: _____