Stony Brook Medicine

Request for an Accounting of Disclosures

Date: _____

Patient Name: _____Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Information: The Health Insurance Portability Act of 1996 ("HIPAA") allows you the right to request an accounting (list) of disclosures made about you for the six years before the request is made. In accordance with HIPAA and at most Stony Brook Medicine sites, the accounting will not include all disclosures made about you. For instance, it will not include disclosures made for the purposes of treatment, payment or health care operations; to friends or family members involved in your care or payment for your care; or as part of a facility directory. The first request in a 12-month period is free of charge. There is a $35 fee for more than one request in a 12-month period.

This request applies to the following Stony Brook Medicine sites (if more than two sites, please attach another page):

1. Name of Site:_____
   Address of Site:_____
2. Name of Site:_____
   Address of Site:_____

Specify the time-period for which you are requesting the accounting of disclosures:

From Date: _____ To Date:_____

Patient or Authorized Representative Name:

Print: _____ Signature: _____

If the request is made by someone other than the patient:
Please tell us what gives you permission to sign for the patient. We reserve the right to ask for proof/documentation.

_____

Please provide contact information: Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Please return the completed form to:
The Stony Brook Medicine Privacy Office
7 Flowerfield, Suite 36, St. James, NY 11780
Fax: (631) 223-4310; Email Address: HIPAA@stonybrookmedicine.edu