SUNY DOWNSTATE Medical Center

EXTENSION NOTIFICATION

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request for Accounting of Disclosures

Dear [Patient Name]:

This letter responds to your request for an accounting of disclosures, which we received from you on _____.

We have been working hard to produce the accounting you have requested. We are usually able to provide an accounting of disclosures within 60 days. However, due to unusual difficulties retrieving the information for the accounting that you have requested, we need an additional 30 days to fulfill your request. We expect to have the accounting available for you no later than _____.

Please contact the Correspondence Unit in the Health Information Management Department of SUNY Downstate Medical Center University Hospital of Brooklyn at (718)270-1845 if you have questions or concerns about this delay.

Sincerely,

Correspondence Unit
Health Information Management Department

SUNY DOWNSTATE Medical Center

ACCOUNTING OF DISCLOSURES- FEE ESTIMATE

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request for Accounting of Disclosures

Dear [Patient Name]:

This letter responds to your request for an accounting of disclosures, which we received from you on _____.

You are entitled to one free accounting every 12 months. Our records indicate that you have already requested and received a free accounting in the past 12 months. That accounting was provided on _____. If you ask us to proceed with your request for an additional accounting of disclosures, we will charge a fee of $ _____ to recover the costs of providing the accounting.

We want you to know that you have the following options. Please check the appropriate box and return within 60 days to SUNY Downstate Medical Center University Hospital of Brooklyn, HIM Department- Box #119, 450 Clarkson Ave., Brooklyn, NY 11203.

- ❑ Proceed with my request. I have enclosed the fee provided in this letter.
- ❑ Withdraw my request. I will pay no fee.
- ❑ Modify my request to reduce the applicable fee. Specify modification of request:

_____

_____

_____

If we do not hear from you within 60 days, we will assume that you have decided to withdraw your request.

Correspondence Unit: (718) 270-1845
Health Information Management Department