SUNY **DOWNSTATE**
Medical Center

PATIENT REQUEST FOR ACCOUNTING OF DISCLOSURES

As our patient, you have the right to request an accounting of disclosures which provides information about certain ways we have disclosed your health information to organizations external to SUNY Downstate Medical Center. Our Notice of Privacy provides a detailed description of how we may use or disclose your information. If you would like to request an accounting after reading the Notice of Privacy, please complete the form below.

Patient Name: _____
                    Last Name   First Name   MI

Address: _____   Telephone:

                _____   _____ (daytime)

                _____   _____ (evening)

I would like an accounting of all disclosures made during the following time period:

(MM/DD/YY)   FROM: ___/___/___   TO: ___/___/___

Please note that we cannot include disclosures that were made prior to April 14, 2003 because we were not required to collect this disclosure information until after that date.

POSSIBLE FEES

You are entitled to one free accounting every 12 months. If you have already requested an accounting within the last 12 months, we may charge a reasonable fee to cover the costs of producing any additional accountings you requested on this form. We will notify you before any fee is charged so that you may decide whether to continue with your request, modify your request to reduce the fee or withdraw your request and pay no fee.

By signing below, I am requesting that SUNY Downstate Medical Center provide me with the accounting described above. I understand that I will be contacted if any fee will be charged for providing this accounting and that I will have an opportunity to modify or withdraw my request if I do not want to pay that fee.

_____   _____
Print Name of Patient/ Personal Representative   Signature of Patient/ Personal Representative

_____   _____
Description of Personal Representative's Authority   Date