



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