



## ACCOUNTING REQUEST FORM

You have the right to receive an accounting of any disclosures made by The Ohio State University College of Optometry of your health and medical information. The following information is required to process your request:

### PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

### REQUESTOR INFORMATION (complete if you are not the patient)

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

Period of time for which you wish to see the disclosures processed \_\_\_\_\_

We are not required by law to include any of the following disclosures of your health information in an accounting to you:

- Disclosures made pursuant to an authorization signed by you or your representative;
- Disclosures to carry out our own or other providers' or plans' treatment, payment and health care operations;
- Disclosures made to you or to your personal representative;
- Disclosures made to persons involved in your care and/or payment or notification of next-of-kin or family members;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody; or
- Disclosures that occurred prior to April 14, 2003

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Please note that we will not process any requests that are not signed by you or your personal representative.

**Return this form to the HIPAA Privacy Officer, The Ohio State University College of Optometry, 338 West Tenth Avenue, Columbus, OH 43210, 614-292-2020**