OPTOMETRY SERVICES

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 infomation 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 authorizaion signed by you or your representative;
- Disclosures to carry out our own or other providers' or plans' treatment, payment and health care opterations;
- 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 purposed;
- 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 will 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, 1664 Neil Ave., Columbus, OH 43210, 614-292-2020

THE OHIO STATE UNIVERSITY
COLLEGE OF OPTOMETRY