NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Weill Cornell Medicine

Columbia
Columbia University
Irving Medical Center

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

This request applies only to the health care provider that you indicate below. If you would like to receive an accounting from one more than one provider, you must complete a separate form for each provider. There is no charge for a requested accounting in any 12-month period. However, we will charge you a reasonable fee based upon our costs for any subsequent request within the 12-month period.

Please complete all sections and print responses:

PATIENT Name:	Middle or Other Name:	Patient Date of Birth: / /	
Patient Street Address:		Patient Apt/Unit/Suite:	
Patient City:	Patient State: ☐ NY ☐ NJ ☐ CT ☐ PA ☐ OTHER:_____	Patient Zip:	
Patient Telephone: ☐ Cell or ☐ Home ( )	Patient Fax Number (if applicable): ( )	Patient Email Address:	

Please specify the facility from which you are requesting an accounting of disclosure of your protected health information:

Hospital/Inpatient Locations

☐ NYP/Allen Hospital
☐ NYP/Brooklyn Methodist
☐ NYP/Columbia University Medical Center
☐ NYP/Hudson Valley
☐ NYP/Lawrence
☐ NYP/Lower Manhattan
☐ NYP/Morgan Stanley Children's Hospital
☐ NYP/Queens
☐ NYP/Weill Cornell Medical Center
☐ NYP/Westchester Division
☐ Gracie Square Hospital

Outpatient/Physician's Office

☐ Columbia University Irving Medical Center (CUIMC)
☐ NYP Medical Group Hudson Valley
☐ Weill Cornell Medicine (WCM)
☐ NYP Medical Group Queens
☐ NYP Medical Group Brooklyn
☐ NYP Medical Group Westchester

Provider(s) Seen: _____

Please specify the **dates** to which the accounting applies. You may not request an accounting of disclosures made before April 14, 2003 or disclosures made more than six years prior to the date of your request. We will provide only disclosures occurring after the date of your last request for an accounting.

Date of Service to Account Disclosure: FROM: _____/_____/_____ **TO**: _____/_____/_____

_____ / /

Signature of Patient or Legal Representative Date

For Organization Use Only:

Date Received by HIM: ____/____/_____ Response Completed by HIM: ____/____/_____