NORTHERN ARIZONA UNIVERSITY

HIPAA Privacy Office
Babbitt Administration
Building 51 Room 100
928-523-6347
PO Box 4116
Flagstaff, AZ 86011-4116

Request for an Accounting of Disclosures of Protected Health Information Form

Name / / Date of Birth (MM/DD/YY)

( )
Phone number E-mail address

Street Address

City/State/Zip

Name of the Northern Arizona University Department or Clinic

I request an accounting of disclosures of my protected health information (PHI) made by the Northern Arizona University department, clinic, or other health care component named above to include disclosures made between the following dates:

(MM/DD/YY) and (MM/DD/YY) (no earlier than six (6) years prior to the date of this request.

I understand that NAU has (60) days to comply with this request. NAU may extend this time period by an additional thirty (30) days if I am provided with the reasons for the delay within the initial sixty (60) day time period. I understand that this list is free one time in any 12-month period. A fee may be charged for additional lists in the same 12-month period.

The accounting I receive will NOT contain disclosures:

- ☐ To carry out Treatment, Payment, or Healthcare Operations;
- ☐ Pursuant to my authorization;
- ☐ Made to me;
- ☐ For the facility's directory;
- ☐ To persons involved in my care or other notification purposes;
- ☐ Incidental to a permissible use or disclosure;
- ☐ For national security or intelligence purposes;
- ☐ To correctional institutions or law enforcement officials;
- ☐ As part of a limited data set;
- ☐ De-identified data;
- ☐ That occurred prior to six years before the date of this request.

Signature: Date:

Description of Authority to sign if personal/legal representative:

Identity of Requestor Verified Via: ☐ photo id ☐ matching signature ☐ other