UCLA DENTAL CLINICS

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patient Name:_____ Date of Birth:_____

1. By signing this form, you are requesting an accounting of the following disclosures for the protected health information of the patient named above. Disclosures for purpose of treatment, payment and health care operations or as part of a limited data set.
2. Disclosures to me or my representatives, or disclosures authorized by me or my representative.
3. Disclosure for use in a UCLA HS (what does HS stand for? Spell) directory.
4. Disclosures to persons involved in my care.
5. Disclosures for notification purposes (to notify a family member, personal representative or other person of the patient's location, general condition or death).
6. Disclosures for national security or intelligence purposes.
7. Disclosures to correctional institutions of law enforcement officials.
8. Disclosures made prior to April 14, 2003.
9. Disclosures incidental to a use or disclosures otherwise permitted, or required by local, state or federal law.

You agree and understand that the right to an accounting of some or all disclosures may be suspended by the government under limited circumstances.

Your request must state a time period that may not be longer than the six (6) previous years. You are requesting an accounting of disclosures for the following time period:

From:_____ To:_____
(Date) (Date)

You are requesting the accounting of disclosures in the following form:

☐ In writing to mailing address:

_____

_____

☐ In-person. Please call me when it is ready:_____
(Telephone #)

You agree and understand that the UCLA Dental Clinics must provide you with the accounting of disclosures within 60 days of its receipt of this request or explain that it needs extra time (up to 30 days) to respond.

You agree and understand that you are entitled to one accounting within any twelve-month period at no cost. For additional requests for accounting within the twelve-month period, there will be a charge for the cost of compiling your accounting.

_____

Patient Signature

_____ _____

Patient Name Date

OR

_____ _____

Patient's Representative Signature Relationship

_____ _____

Patient's Representative Name Date

When you have completed this form, please return it
to: Dr. Sean Mong
General Clinic Director
UCLA School of Dentistry
Box 951668
10-136 Center for the Health Sciences,
Los Angeles, CA 90095-1668