Health
AUGUSTA UNIVERSITY

DOB: EMRN:

ACCT #:

LOCATION:

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Request for Accounting of Disclosures

Patient Name:	Patient Number:
Date of Birth:	Last 4 Digits of Social Security Number:

Mail disclosure accounting to:

Street Address:	
City, State & Zip	

Dates Requested:

I would like an accounting of all disclosures of my health record for the following time frame. (*Please note the maximum time frame that can be requested is six years prior to the date of this request.)*

From: _____ To: _____

Fees:

No charge for the first request in a 12-month period. Subsequent requests will be based on cost to process request including but not limited to labor costs and off-site storage retrieval fees.

The fee estimation for this request will be:_____

I understand there is a fee for this accounting and wish to proceed. I also understand the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed to process the request.

_____ _____ _____

Signature of Patient or Legal Representative/(Relationship to Patient) Date Time

Mail to: AU Medical Center
HIMS BPM-210
1120 15th Street
Augusta, Georgia 30912

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** FOR AU HEALTH USE ONLY **

Date Request Received:	Extension Requested: ☐ No ☐ Yes
Date Request Fulfilled:	If Yes, Reason:
Staff Member Processing Request:	
	Patient Notified of Extension on this date: