UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM | MILLER SCHOOL OF MEDICINE UNIVERSITY OF MIAMI

Attachment 45
HIPAA Accounting for Disclosure Form

Date of Disclosure: ______________________ Medical Record Number: ______________________

Patient Name: ______________________ Date of Birth: ______________________

Phone Number: ______________________ Last 4 Digits of SSN: ______________________

RECORD OF DISCLOSURE OF HEALTH INFORMATION

To Custodian of Patient Information: Federal privacy standards issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the University of Miami and/or Jackson Health System to record and, upon patient request, account for disclosures of patient information for purposes other than treatment, payment, or health care operations. A process for creating the records to provide such an accounting and for responding to patient requests is provided in the UM HIPAA Privacy Policy and Procedure Manual.

Accounting Required for the Following Disclosures:

- Disclosures for Research purposes when a waiver has been approved by the IRB, for disclosure of deceased individual information, or for disclosures of information to third parties for research preparation
- Disclosures required by law
- Disclosures for public health activities
- Disclosures about victims of abuse, neglect, or domestic violence
- Disclosures for health oversight activities
- Disclosures for judicial or administrative proceedings
- Disclosures for law enforcement purposes
- Disclosures about decedents
- Disclosures about cadaveric organ, eye, or tissue donation purposes
- Disclosures to avert serious threat to health or safety
- Disclosures for specialized government functions
- Disclosures for worker's compensation

Please provide the following information:

Recipient of Patient Information: ______________________

Recipient Contact Information (including address and phone number):

____

____

Description of Patient Information Disclosed:

____

____

Purpose of Disclosure:

____

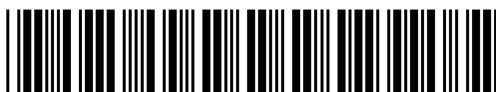
____

FOR UNIVERSITY OF MIAMI USE ONLY, PLEASE PRINT: Please send the original to the Office of HIPAA Privacy & Security. Please send a copy to the Departmental Records Custodian. For additional assistance, please call the University of Miami Office of HIPAA Privacy & Security at 305-243-5000.

Name of UM Representative	Department Name	Contact Telephone	Date

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **305-243-5000 1-866-366-4874**

HIPAA ACCOUNTING FOR DISCLOSURE FORM



Form D3900048E

Revised 11/21/08

NAME: ______________________

MRN: ______________________

LAST 4 DIGITS OF SSN: ______________________

DOB: _____/_____/_____

DATE: ______________ TIME: ______________

© 2008 University of Miami