

# TULANE UNIVERSITY MEDICAL GROUP REQUEST FOR AN ACCOUNTING OF DISCLOSURES

## 1. PATIENT INFORMATION

<b>Date of Request:</b>	<b>Medical Record or Billing Number:</b>
<b>Name:</b>	<b>Date of Birth:</b>
<b>Social Security Number:</b>	<b>Telephone Number:</b>
<b>Address:</b>	
<b>Address to send Accounting of Disclosure (if different than above):</b>	

## 2. DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note:* the maximum time frame that can be requested is six years prior to the date of your request, and we are not required to account for disclosures that occurred before April 14, 2003.

From: \_\_\_\_\_ To: \_\_\_\_\_

## 3. FEES

There is no charge for the first request for an accounting in a 12-month period. For subsequent requests in the same 12-month period, the charge is \$25.00. I understand that there is (check one):

- No fee for this request.
- A fee for this request in the amount of \$25.00, and I wish to proceed.

## 4. RESPONSE TIME

I understand that the accounting I have requested will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Signature of patient or  
Legal representative \_\_\_\_\_ Date \_\_\_\_\_

## 5. THIS SECTION FOR HEALTH CARE ORGANIZATION USE ONLY

Date request received: \_\_\_\_\_ Date accounting sent: \_\_\_\_\_

Requestor verified by which method? \_\_\_\_\_

Extension requested:    no            yes

If yes, give reason: \_\_\_\_\_

Patient notified in writing on this date: \_\_\_\_\_

Staff member processing request: \_\_\_\_\_

\*\*This completed form will be permanently maintained with the permanent medical or billing or Privacy Official record\*\*

\*\* You have a right to receive a copy of this form after you have signed it\*\*

**TULANE UNIVERSITY**  
**APPLICATION FOR I.R.B. WAIVER OR ALTERATION AUTHORIZATION**

Project title: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

1) Describe the protected health information you plan to review and the purpose for your review. Protected health information may not be reused or disclosed to any other person or entity, except as required by law.

2) Describe or list sources of names of patients whose PHI will be included in this review (e.g. search of electronic records or lab database, review of physician's cases, review of departmental log or census).

3) If this review is to identify prospective research subjects, describe the plans for contacting prospective subjects. For reviews preparatory to research, protected health information may not be removed from the covered entity's site.

4) Describe the plans to protect subject identifiers from improper use and disclosure.

5) Describe plans to destroy the participant identifiers at the earliest opportunity consistent with the research unless retention is required for reasons of health, research, or law. Please explain when/if the participant identifiers will be stored or retained. If there is a health or research justification for retaining the identifiers, please explain.

6) Explain why the research could not practicably be conducted without the waiver.

7) Explain why the research could not be practicably conducted without access to and use of the PHI.

My research team and I will comply with the use and disclosure restrictions described above.

\_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

**TULANE UNIVERSITY MEDICAL GROUP**  
**PATIENT REQUEST FOR AMENDMENT OF RECORDS**

*You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information. To request an amendment to your records, complete and return the following request form.*

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Last

First

MI

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone:

\_\_\_\_\_ (daytime)  
\_\_\_\_\_ (evening)

Email Address (optional):

\_\_\_\_\_

**AMENDMENT REQUEST**

*Please answer the following questions. You may attach a separate page if more space is needed.*

**What information would you like to amend?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How do you believe the information should be amended?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is this request being made because of an emergency or other urgent situation? If so, please describe the nature of the emergency or urgency below and the date you need the information amended. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable requests.**

\_\_\_\_\_  
\_\_\_\_\_

**PATIENT UNDERSTANDING AND SIGNATURE**

By signing below, I am requesting that Tulane University Medical Group amend my health information as I have explained above.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

SEND COMPLETED FORM TO THE SPECIFIC SITE  
(ONE OF THE FOLLOWING):

1. Tulane Orthopaedic Clinic – Covington  
71211 Highway 21, Suite A  
Covington, LA 70433
2. Tulane Orthopaedic Clinic – Slidell  
1051 Gause Blvd., Suite 230  
Slidell, LA 70458
3. Tulane Dermatology Clinic – Covington  
71211 Highway 21, Suite B  
Covington, LA 70433
4. TUMG Billing Office  
Attention: Chief Operating Officer  
1430 Tulane Ave. – TW 22  
New Orleans, LA 70112-2632

**For Internal Use Only:**

Date Received: (MO/DY/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_

Disposition of Request: \_\_\_\_ GRANTED \_\_\_\_ DENIED \_\_\_\_ PARTIALLY DENIED

Patient Notified In Writing On This Date: (MO/DY/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Employee Processing This Request: \_\_\_\_\_

**REVOKE AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION (PHI)**

Patient's Name:	Birth Date:	SS#:
Address:		Telephone #:

I hereby REVOKE authorization from

\_\_\_\_\_

to release the health information of

\_\_\_\_\_

to

\_\_\_\_\_

that was granted for the purpose of

\_\_\_\_\_

Type of access that was granted:

- |  |
|--|
| <input type="checkbox"/> Entire Medical Record<br><input type="checkbox"/> Itemized bill<br><input type="checkbox"/> Other _____ |
|--|

\_\_\_\_\_  
(Date) (Signature of Patient/Guardian/Patient Representative) (Relationship to Patient)

\_\_\_\_\_  
(Printed name)

\*Revocation of authorization for release of information except to the extent the action has been taken in reliance upon it.

**TULANE UNIVERSITY MEDICAL GROUP**

**PATIENT REQUEST FOR ACCESS TO  
HEALTH INFORMATION**

*Our patients have the right to inspect and obtain a copy of most information in our records that may be used to make decisions about them or their treatment for as long as we maintain the information in our records. Patients may also request that we provide a summary of the information (instead of copies) or an explanation of complicated information. Please see our Notice of Privacy Practices for a more detailed description of these rights and the process we follow once we have received a request. To request access to records, please complete and return the following request form.*

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Last

First

MI

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone:

\_\_\_\_\_  
\_\_\_\_\_ (daytime)  
\_\_\_\_\_ (evening)

Email Address (optional):

\_\_\_\_\_

**ACCESS REQUESTED**

*Please answer the following questions. You may attach a separate page if more space is needed.*

**What information would you like to access? If you can, please provide the dates that tests were performed or treatment was provided.**

\_\_\_\_\_  
\_\_\_\_\_

**What type of access are you requesting?** Check all that apply:

INSPECT \_\_\_\_\_ COPY \_\_\_\_\_ SUMMARY \_\_\_\_\_ EXPLANATION \_\_\_\_\_

*If your request to inspect the information is granted, we will provide you with further information on how to schedule an appointment with our staff to inspect your records.*

**If you are requesting a copy, summary, or explanation of the information, how would you like these materials delivered to you? You may pick up these materials at our facility or request that we send them to you by regular mail.**

Check one: PICK UP \_\_\_\_\_ BY MAIL \_\_\_\_\_

**If your request is being made because of an emergency, please describe the nature of the emergency and the date you need the information. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable requests.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FEES**

**Copying and Distribution Costs.** We will charge you a reasonable fee to recover the costs of copying. Our standard fee for copying is \$.10 per page or \$5.00 for items we can't reproduce with a photocopier (e.g., x-rays, mammograms). We will not contact you before this information is prepared.

**Summary or Explanation.** We will also charge a fee to recover the costs of providing any summary or explanations you have requested.

**PATIENT UNDERSTANDING AND SIGNATURE**

By signing below, I am requesting that Tulane University Medical Group provide me with access to health information in the manner described above. I understand that I will be expected to pay the fees for a summary or explanation for fulfilling this request.

\_\_\_\_\_  
Signature of Patient or Personal Representative

**SEND COMPLETED FORM TO:**

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

**For Internal Use Only:**

Date Received: (MO/DY/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_

Disposition of Request: \_\_\_\_ GRANTED \_\_\_\_ DENIED \_\_\_\_ PARTIALLY DENIED

Patient Notified In Writing Of Response To Request On This Date: (MO/DY/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_

Fee Charged For Fulfilling This Request (if applicable): \$ \_\_\_\_\_

Name or Initials of the manager of the specific site who is processing this request:  
\_\_\_\_\_

**TULANE UNIVERSITY MEDICAL GROUP**  
**ACCESS PROVIDED TO PATIENT OR**  
**PATIENT'S PERSONAL REPRESENTATIVE**

**Patient Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

*This form must be completed by the manager of the specific site or the FPP Billing Office when a patient is granted access to his or her health information, or the patient's personal representative is granted access to the patient's information. The manager completing this form should remember to print his or her name where provided and sign and date the form.*

**RECIPIENT OF ACCESS**

*Check the appropriate box:*

**Who received access to the information?**     Patient     Patient's Personal Representative

**INSPECTION**

*Complete this section if the patient or personal representative was permitted to inspect information:*

**What information was the patient or personal representative permitted to inspect?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**When did the patient or personal representative inspect this information?**

(MO/DY/YR) \_\_\_/\_\_\_/\_\_\_

**COPIES**

*Complete this section if the patient or personal representative was provided with copies of information.*

**What information was the patient or personal representative permitted to copy?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How were these copies provided?**

Check one: PICK UP \_\_\_\_\_ BY MAIL \_\_\_\_\_

Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**When were these copies provided?** (MO/DY/YR) \_\_\_/\_\_\_/\_\_\_

**What fee was charged to the patient or personal representative for providing these copies?**

\$ \_\_\_\_\_

**SUMMARY OR EXPLANATION OF INFORMATION**

*Complete this section if the patient or personal representative was provided with a summary or explanation of the requested information.*

**What is the title of that summary or explanation?**

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**Has a copy of the summary or explanation been added to the patient's medical record?**

Yes \_\_\_\_\_

Date \_\_\_\_\_

**Who prepared the summary or explanation?** \_\_\_\_\_

**What fee was charged to the patient for providing this summary or explanation?**

\$ \_\_\_\_\_

\_\_\_\_\_  
Signature of the manager of the specific site

\_\_\_\_\_  
Print name of the manager of the specific site

\_\_\_\_\_  
Date

***REMINDER:***  
**ADD THIS FORM TO THE**  
**PATIENT'S MEDICAL RECORD (OR**  
**BILLING RECORD FOR FPP**  
**CLAIMS) ALONG WITH COPIES OF**  
**ANY SUMMARIES OR**  
**EXPLANATIONS PROVIDED TO**  
**THE PATIENT**

