**Cornell Health**

The Ceriale Center for Cornell Health
110 Ho Plaza
Ithaca, New York 14853-3101
t. 607.255.5155
f. 607.255.0269
health.cornell.edu

**Cornell University**

## Patient/Client Request for an Accounting of Disclosures

The Health Insurance Portability and Accountability Act ("HIPAA") gives you the right to receive an accounting of certain disclosures of your health information that are made by Cornell Health and its Business Associates for up to six (6) years prior to the date of your request. You are not entitled to receive an accounting of disclosures that are made to carry out treatment, to obtain or make payment for treatment, or for health care operations. You are not entitled to receive an accounting of disclosures that are made to you or pursuant to your authorization, to your family or other persons involved in your care, or for national security or certain law enforcement purposes.

You are entitled to one free accounting every 12 months. If you have already requested an accounting within the last 12 months, we will charge you a reasonable fee of $50 to cover the costs of producing an additional accounting. You will receive the accounting via certified mail within 60 days of receipt of your request.

To request an accounting of disclosures, please complete the form below and send to:
    Privacy Officer, Cornell Health, 110 Ho Plaza, Ithaca, NY 14853-3101

1. **Patient/client information** (*print clearly*):

    Name _____    Date of birth (*mm/dd/yyyy*) _____

    Email address _____    Phone number _____

    Mailing address _____

2. **Send Accounting of Disclosures to this address** (*if different from above*):

    _____

3. **I request an Accounting of Disclosures that were made during the following time frame:**

    From (*mm/dd/yyyy*) _____ to _____

4. **I understand that, if I have already received an accounting within the last 12 months, I will be charged a reasonable fee of $50; and I agree to pay the fee.**

    Signature _____    Date _____    Time _____
    _____*patient/client or person authorized to sign*_____                       *mm/dd/yyyy*              *a.m. / p.m.*

    * If the consenting party is other than the patient/client, print name and relationship to patient/client:

    _____

CORNELL HEALTH
USE ONLY          Received: _____/_____/_____    Completed: _____/_____/_____    Initials: _____

*This request must be maintained in the patient's health record.*