Texas Tech University Health Sciences Center **Request for an Accounting of Certain Disclosures of Protected Health Information**	Patient Name:_____ MRN:_____ DOB:_____

Patient Contact information:

Street Address _____

City, State, ZIP _____

Phone number _____

I request and authorize Texas Tech University Health Sciences Center to provide me an accounting of disclosures of my protected health information for the time period:

_____

_____

_____

As a patient, you have the right to receive an accounting of certain non-routine disclosures of your protected health information made by TTUHSC. Please see our Notice of Privacy Practices for more information on disclosures of protected health information. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The first list you request in a 12-month period will be provided free of charge. For additional lists during the same 12-month period, you may be charged for the costs of providing the list. You may withdraw or modify your requests in order from being charged for the additional list.

_____	_____	_____
Date	Time	Patient/Other legally authorized person
_____	_____	_____
Witness	Print Name	Print name and relationship to patient