TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO **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 El Paso 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 El Paso. 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 to avoid being charged for the additional list.

Date	Print Name	Signature Patient/Other legally authorized person