UNIVERSITY OF VIRGINIA HEALTH SYSTEM

1500000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Patients may request an Accounting of Disclosures that lists disclosures of medical information about them that were not for treatment, payment or health care operations and of which they were not previously aware. To request an Accounting, please complete this form and return to:

University of Virginia Health System
Release of Information, Health Information Services, Box 800476
Charlottesville, Virginia 22908 – Telephone: (434) 924-5136

Patient Name: _____ MRN _____

Address: _____ Date of Birth _____

City _____ State _____ Zip Code _____

Home Telephone Number _____ Work Telephone Number _____

Address to send disclosure accounting (if different from above):

_____

_____

DATES REQUESTED:
I would like an Accounting of Disclosures for the following time frame:
(Please note: the maximum time frame that can be requested is six years prior to the date of request, but not before 4/13/03)

From: _____ To: _____

FEES:
First request in a 12-month period: Free
Subsequent requests: $10 for each additional request in a 12-month period. Fee should accompany the request. Checks should be payable to **UVA Health System**.

I understand that there is a fee for this Accounting and wish to proceed. I also understand that the Accounting 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

For Release of Information, HIS Use Only:

Date Received: _____ Date Sent: _____

Extension Requested: ☐ No ☐ Yes, Reason _____

Patient Notified in Writing on this Date: _____

Staff Member Processing Request: _____