UNIVERSITY OF VIRGINIA HEALTH SYSTEM

1500000

PLACE LABEL HERE

September 29, 2015
FORM NO. 100367

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

REQUEST FOR NON-DISCLOSURE OF HEALTH INFORMATION TO HEALTH PLAN

You have the right to require that information about a particular health care service not be disclosed to your health plan **If you have paid for that service in full (based on the full cost estimate).**

This service is to be performed on a date when this is the only service that you will receive at the Medical Center.

You understand and acknowledge that you must pay the full estimated cost before this service will be provided and the request acted upon. If there are additional unexpected charges, you are expected to pay the bill in full within 45 days of the date of service. Your request for non-disclosure of health information to your health plan is irrevocable after the service has been provided.

In the future, if you submit a release of information request form to the University of Virginia Health System for release of your entire medical record to your health plan, it is your responsibility to note on the form that you do not wish information about this service to be released.

You understand and acknowledge that if you return to the University of Virginia Health System on a different date and you do not want information about that service released to your health plan, you must fill out another 'Request for Non-disclosure of Health Information to Health Plan' form per the same process.

To request non-disclosure of information to your health plan, please complete the following sections of this form and return it to a scheduling or registration staff member.

Describe the service you want to receive from the University of Virginia Health System that you do not want to be disclosed to your health plan:

_____

_____

_____

Specify which health plan you do not want to receive information about this service:

_____

Patient's Name: _____ Date of Birth: _____

Address: _____

_____

UVA Medical Record Number if known: _____ Date Initiating Request: _____

Phone Number to Contact Patient: _____

Patient or Legal Representative Signature: _____

REQUEST FOR NON-DISCLOSURE OF HEALTH INFORMATION TO HEALTH PLAN

To be completed by your physician, clinician, or their designee:

Clinic area & contact person/number: _____

_____

CPT codes with their descriptions and supplies for the above requested service:

_____

_____

To be completed by UVA team:

Full estimated cost for the above service: **$**_____

Date and time patient notified of estimated cost: _____

Name and title of Scheduler that notified patient of cost: _____

Patient requests to withdraw the request at this time: Yes*:_____ No:_____

*If yes, inform the patient his/her request will be withdrawn and the form will be sent to Health Information Services.

Patient requests to proceed with scheduling: Yes:_____ No:_____

Date payment in full received: _____

Date service scheduled: _____

Date the patient was handed or mailed a copy of this completed form: _____

To Withdraw This Request Prior to Services Provided: To be completed by the patient or legal representative: I request to withdraw the above request and have my health plan billed for this service.

Date: _____

Patient or Legal Representative Signature: _____

INTERPRETER ATTESTATION (when applicable)

Interpretation has been provided by

_____ _____

SIGNATURE OF INTERPRETER/CYRACOM ID# DATE/TIME

UVA Health System Team, send the original completed form via messenger mail to:

University of Virginia Health System
Release of Information
Health Information Services
P.O. Box 800476
Charlottesville, VA 22908-0476
Telephone: (434) 924-5136