UVA Health

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:

☐UVA Health Medical Center
PO Box 800476
Charlottesville, Va. 22908
434-924-5136
434-924-2432 (Fax)
CLHIMDCT@hscmail.mcc.virginia.edu

☐ UVA Health Prince William Medical Center
8700 Sudley Rd
Manassas, Va. 20110
703-369-8297
703-369-8285 (Fax)
uvachrecordsrequest@uvahealth.org

☐UVA Health Haymarket Medical Center
15225 Heathcote Boulevard
Haymarket, Va. 20169
703-369-8297
703-369-8285 (Fax)
uvachrecordsrequest@uvahealth.org

☐UVA Health Culpeper Medical Center
501 Sunset Lane
Culpeper, Va. 22701
540-829-4386
540-829-4326 (Fax)
ROICulpeper@uvahealth.org

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:

From: _____ to: _____

Please note that Accounting of Disclosures are maintained for a maximum of 6 years prior to the date of the request.

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