UVA Health

1500011

PLACE LABEL HERE

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

REQUEST FOR NON-DISCLOSURE OF HEALTH INFORMATION TO HEALTH PLAN

Patients have the right to request a restriction or limitation on use or disclosure of their medical information to a health plan if paying for health services out of pocket in full. To make this request, please complete this form and return it to a scheduling or registration staff member.

_____ _____
(Patient's full name) Birth date (Mo/Day/Yr)

_____ _____
(Street address) Medical Record Number

_____ _____
(City, state, zip code) Phone

I,_____, hereby request the University of Virginia Health System to restrict the use or disclosure of my protected health information to my health plan involved in the payment of my care for services paid out of pocket in full (based on the full cost estimate) prior to the service being provided as specified below. I understand that:

- I am required to pay, in-full, the projected amount for my services before they occur or this request will be null and void and my insurance may be billed without notice and I may be billed for any additional charges that must be paid within forty-five (45) days of my service
- If applicable, I will need to ask my prescribing provider to provide me with a paper prescription toensure that my medication is not billed or disclosed to my health plan
- Some lab tests are done by an external vendor and I may have to contact one of them to obtain a restriction from their billing.
- This restriction request covers only the encounter specified below. If I want information from other dates of service restricted, I will need to fill out another form for each visit.

Name of Health Plan: _____ Date of Service:_____ Department:_____
Reason for visit: _____

Acknowledgement: By submitting this form, I hereby request the University of Virginia Health System to restrict uses and disclosures of my health information as described above. I understand and acknowledge that the above stated organization is not required to agree to my request.

_____ _____
Print name of Patient or Legal Representative Relationship to Patient

_____ _____
Signature of Patient or Legal Representative Date