



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:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> UVA Health Medical Center
PO Box 800476
Charlottesville, Va. 22908
434-924-5136
434-924-2432 (Fax)
CLHIMDCT@hscmail.mcc.virginia.edu | <input type="checkbox"/> UVA Health Prince William Medical Center
8700 Sudley Rd
Manassas, Va. 20110
703-369-8297
703-369-8285 (Fax) | <input type="checkbox"/> UVA Health Haymarket Medical Center
15225 Heathcote Boulevard
Haymarket, Va. 20169
703-369-8297
571-284-1429 (Fax) | <input type="checkbox"/> UVA Health Culpeper Medical Center
501 Sunset Lane
Culpeper, Va. 22701
540-829-4386
540-829-4326 (Fax)
ROI@culpeperhospital.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