UNIVERSITY OF VIRGINIA HEALTH SYSTEM

1500008

PLACE LABEL HERE.

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

REQUEST FOR RESTRICTION ON USES & DISCLOSURES OF HEALTH INFORMATION

Patients have the right to request a restriction or limitation on use or disclosure of their medical information for treatment, payment, or health care operations, or to someone who is involved in their care. To request a restriction, please complete this form and return to:

University of Virginia Health System
Release of Information, Health Information Services
P.O. Box 800476
Charlottesville, VA 22908-0476

Telephone: (434) 924-5136

Patient's Name: _____ Date of Birth: _____

Address: _____

MRN (For UVA use only): _____

Dates of Restriction From: _____ To: _____

Describe the restriction you are requesting of the University of Virginia Health System in its uses and disclosures of your health information. Specify what information you want to limit, whether you want us to limit use or disclosure, and to whom you want the limits to apply:

_____
_____
_____
_____
_____
_____

Information on your rights to request a restriction. You have the right to ask us to restrict how the University of Virginia Health System uses and discloses your health information for purposes of treatment, payment, or health care operations. You also have the right to ask us to restrict disclosures we make to those family members or others involved in your care or involved in payment for your care, or to outside entities, such as disaster relief organizations, to notify family members or others involved in your care of your location and condition. We are not required to agree to your request. If we do agree, we will put the agreement in writing and will abide by the agreement, unless your health information is needed to provide you emergency treatment. If we do not agree to your request, we will notify you of our decision in writing. You may terminate a restriction that we have agreed to, at any time, by contacting the University of Virginia Health System at the address above. If we agree to a restriction, we are allowed to terminate that agreement at a future date, but only regarding health information recorded in the University of Virginia Health System records after we notify you that the restriction is terminated.

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 Date

_____
Signature of Patient or Legal Representative

FOR HEALTH SYSTEM USE ONLY
Date Form Received: _____
Restriction Has Been: ☐ Accepted ☐ Denied
Authorized By: _____
Date Patient Notified in Writing of the Denial of the Restriction:_____