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
uvachrecordrequest@uvahealth.org

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

☐ UVA Health Haymarket Medical Center
15225 Heathcote Boulevard
Haymarket, Va. 20169
703-369-8297
uvachrecordrequest@uvahealth.org

☐ UVA Health Culpeper Medical Center
501 Sunset Lane
Culpeper, Va. 22701
540-829-4386
ROI@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 ___________