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:

☐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)
uvachrecordrequest@uvahealth.org

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

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

Patient's Name:_____ Date of Birth: _____ Address:

_____ MRN

(For UVA use only): _____

Dates of Restriction From:_____ To: _____

Requested Media to be Restricted:

☐**CareEverywhere-** A tool within the Epic electronic medical record that is used to securely share patient records with other Epic healthcare facilities and providers for treatment

☐All other release of information methods, including, but not limited to, releases by UVA Health, for treatment, payment, or healthcare operations

Describe the restriction you are requesting of UVA Health 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 UVA Health 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 UVA Health 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 UVA Health records after we notify you that the restriction is terminated.

Acknowledgement: By submitting this form, I hereby request UVA Health 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