Request to Restrict Disclosure of Healthcare Items or Services to Health Plans When Patients Self Pay Out of Pocket

I request that UW Medicine not disclose healthcare items or services to my health plan because I am self-paying for the item(s) or service(s) listed below, for the specific date(s) listed below.
I understand that:

- I must pay the full amount for these services in advance of the visit and if I do not, UW Medicine is not required to honor this request
- This restriction does not include complications from the healthcare item(s) or service(s).

My health plan's name:_____

Please list the healthcare item(s) or service(s) being paid for in advance of the visit.	**Date of Service**
1.	
2.	
3.	
4.	
5.	

Please send completed form to:

UW Medicine Health Information Management
325 Ninth Ave
Box 359738
Seattle, WA 98104
Fax: 206.744.9997
Phone: 206.744.9000

_____, _____,
NAME OF PATIENT BIRTHDATE

Signature *(Patient Or Person Authorized To Give Authorization)*	Date
If signed by person other than patient, provide reason, relationship to patient, description of their authority.	

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

REQ TO RESTRICT DISCLOSURE–SELF-PAY EXPENSES

*U2923

UH2923 REV JUL 14

WHITE – MEDICAL RECORD
CANARY - VARIABLE