Request for Restriction or Termination of Restriction on Uses and Disclosure of Protected Health Information (PHI)

Please print all requested information to prevent delays & provide completed form to your facility

Patient Name:_____
Last **First** **MI** **Maiden or Other Name**

Address: _____ **City:**_____ **ST:**_____ **Zip:**_____

Date of Birth:_____-_____-_____ **Phone #:**_____

Please understand that:

- We are not required to agree to this restriction request, unless it is restricting disclosure of your PHI to a health plan or carrier for treatment or services for which **you have paid in full**. We may remove the restriction if your payment is not honored.
- We may voluntarily agree to other requests for restrictions. Any restrictions to which we have voluntarily agreed may be terminated by informing you of the termination.
- This restriction will not apply to any disclosures of PHI which occurred prior to implementation of this request.
- Restrictions will not apply when the restricted information is needed for emergency treatment.
- Restrictions cannot apply to workers' compensation.
- You may request termination of a previous restriction at any time.

I am requesting that you: ❑ Place a restriction ❑ Remove a previous restriction on the use or disclosure of my protected health information:

Description of Information to be Restricted:

_____

_____

_____

Date of Service: _____

❑ Individual/Entity to whom PHI should not be disclosed:_____

❑ Other: _____

SIGNATURE OF PATIENT **DATE**

OR

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON **DATE**

RELATIONSHIP TO PATIENT **DATE**

Request for Restriction or Termination of Restriction on Uses and Disclosure of Protected Health Information (PHI)

Please print all requested information to prevent delays in our response & provide completed form to your facility.

FOR INTERNAL USE ONLY

Complete the sections below and place in patient record.

Notice of Decision

- ❑ We have accepted the restriction(s) you have requested above.
- ❑ We have accepted only the following portion of the restriction(s) you have requested above:

_____

- ❑ We are unable to accept the restriction(s) you have requested above.
- ❑ We are informing you that the above restrictions are being terminated._____
  Date
- ❑ Termination request on previous restriction has been completed._____
  Date

_____ _____

Name of associate that processed request Date Request was processed