REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____
Patient Address: _____ **Date**:_____

Section A: Patient (or Legal Representative) to complete the following information:

Information Restriction

I am requesting a restriction on the use/disclosure of my protected health information (PHI) in the manner described below. I understand that The Care Team may deny this request. If my request is approved, I understand that the restriction will not apply in cases where I need emergency treatment.

Restrictions for Treatment, Payment or Operations will only apply for visits/encounters that were paid in full by me; out of pocket.

Description of Specific Health Information to be Restricted: _____
_____

Persons/Organizations Restricted from Use/Disclosure: _____
_____

Other Restrictions (please specify): _____
_____
_____
_____

Signature of Patient/Legal Representative: _____Date: _____
Printed Name: _____ Date: _____
Legal Representative Relationship to patient: _____

Section B: The Care Team to complete the following information:

Your request for restriction has been: ☐ Accepted* ☐ Denied
**In the case of an emergency or when necessary to comply with the law, we may use and disclose your health information despite the restrictions requested herein until you terminate these restrictions.*

Signature of Compliance Manager: _____Date: _____
Printed Name:_____

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Patient Name: _____ **Date of Birth**: _____
Patient Address: _____ Date:_____

Section C: The Care Team and the Patient, if possible, complete this section:

Termination of Restriction

☐ The above-named patient agreed to terminate this restriction on (Date): _____

☐ The above-named patient was notified on (Date): _____ that this restriction was terminated.

Patient was notified:

☐ In person

☐ By telephone (attach documentation)

☐ By mail (attach documentation)

Signature of The Care Team Representative: _____Date: _____
Printed Name:_____
(If possible), Signature of Patient or Legal Representative: _____Date: _____
Printed Name:_____
Legal Representative relationship to patient: _____

Distribution of copies: Original to Individual's record, copy to Individual