

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

PATIENT INFORMATION:

Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

I understand that by signing and submitting this form, I am hereby requesting the name of the clinic below to restriction on the use and disclosure or my protected health information.

Name of Clinic

I understand the following:

<ul style="list-style-type: none"> ♦ This restriction will not apply to any disclosures of PHI that occurred prior to implementation of this request. 	<ul style="list-style-type: none"> ♦ Restrictions will not apply when the restricted information is needed for emergency treatment.
<ul style="list-style-type: none"> ♦ You may request termination of a previous restriction at any time. 	<ul style="list-style-type: none"> ♦ Restrictions cannot apply to workers' compensation.
<ul style="list-style-type: none"> ♦ 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. 	
<ul style="list-style-type: none"> ♦ We are not required to agree to this restriction request, unless it is to restrict 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. 	

Request: Place a Restriction Remove a previous restriction

Date of Service: _____

Description of information to be restricted _____

Name of Individual /Entity to whom PHI should not be disclosed:

Other: _____

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Print Name

Date

Signature

Name of Interpreter/Translator (if required)

Phone Number

***If a translator or interpreter was required.**

OFFICE USE ONLY

Notice of Decision

Restriction(s) Status:

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

Termination of Restriction:

- Termination requested on previous restriction has been completed
Effective Date: _____
- We are informing you that the current restrictions are being terminated
Effective Date: _____

Date request was received: _____

Date request was processed/completed: _____

Facility Name

Office Personnel (Print Name)

Date

Office Personnel Signature