Request for a Restriction on Use or Disclosure of Health Information

PATIENT		
•		
Name (Last, First Middle)	Date of Birth	
Record Number		
REQUESTED RESTRICTION		
Nature of Restriction Requested (be specific):		
I request no disclosure be made to my health in	surer be made related to the following item or service, fo	or which I have paid in full:
Name of Health Insurer		
I request no disclosure of the following informati	ion:	
to the following person[s]/entity:		
We will agree to your request to restrict disclosure of you have paid, or someone other than the health plan has p	our PHI to a health plan if the PHI pertains solely to a heapaid on your behalf, in full.	alth care item or service for which you
We will try to accommodate all reasonable requests for restriction consistently.	r a restriction, but reserve the right to deny a request if it	would be infeasible to implement the
Please note that, by law, we may be required to make the following circumstances:	the following types of disclosures, and so any restriction	we agree to will not affect disclosures in
In the event you develop an emergency medical	al condition, we will use and/or disclose information for el	mergency treatment;
	n or opportunity to agree or object is not required; such a buse, neglect or domestic violence and research;	as in the cases of national security, public
Disclosures required by the Secretary of the De	epartment of Health and Human Services to investigate of	or determine our compliance with HIPAA.
Signature of individual or personal representative	(if representative, relation to p	patient) Date
OFFICIAL USE ONLY		
Oral Request		
Request Accepted		
Request Denied because:		
Signature	Title	Date
Copies to:		
Individual Patient		
Individual's Medical Record		

