# 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 insurer be made related to the following item or service, for which I have paid in full:

**Name of Health Insurer**

☐ I request no disclosure of the following information:

to the following person[s]/entity:

We will agree to your request to restrict disclosure of your PHI to a health plan if the PHI pertains solely to a health care item or service for which you have paid, or someone other than the health plan has paid on your behalf, in full.

We will try to accommodate all reasonable requests for a restriction, but reserve the right to deny a request if it would be infeasible to implement the restriction consistently.

Please note that, by law, we may be required to make the following types of disclosures, and so any restriction we agree to will not affect disclosures in the following circumstances:

- In the event you develop an emergency medical condition, we will use and/or disclose information for emergency treatment;
- Uses and disclosures for which an authorization or opportunity to agree or object is not required; such as in the cases of national security, public health activities, law enforcement, victims of abuse, neglect or domestic violence and research;
- Disclosures required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA.

**Signature of individual or personal representative** | **(if representative, relation to patient)** | **Date**

## OFFICIAL USE ONLY

☐ Oral Request

☐ Request Accepted

☐ Request Denied because:

**Signature** | **Title** | **Date**

**Copies to:**

☐ Individual Patient

☐ Individual's Medical Record