Request For Restriction and Limitation of Protected Health Information

NOTE: Complete <u>One</u> Form Per Patient

PATIENT INFORMATION:

Name	**Date of Birth**
Street Address	
Email Address	**Phone Number**

1. **Dates of the information to be restricted:**
   For example: Dates of office visits, treatment, or other health care services.

   _____

   _____

2. **Describe the information to be restricted:**
   For example: Lab results, physician notes.

   _____

   _____

   _____

3. **How would you like you Protected Health Information (PHI) restricted?**
   For example: Restrict access to a particular entity or individual.

   _____

   _____

   _____

4. **What is the reason for your request?**

   _____

   _____

   _____

I understand that I have the right to request restrictions on the use and disclosure of my protected health information (PHI). I also understand that the practice is not required to agree to my request. I understand that I can terminate the requested restriction at any time, in writing, and the practice can terminate this agreement upon reentry written notification to the patient or legal representative.

I understand that practice must agree not to disclose my PHI to my health plan if the disclosure is for payment or healthcare operations related to a health care item or service which I paid for in full, out of pocket. I also understand that if my request is accepted, the practice may not use or disclose my PHI in violation of the restriction unless it is needed to provide emergency treatment, or the law mandates such use or disclosure.

Signature of Legal Representative/Patient 18yrs or older	**Date**
Printed name of Legal Representative/Patient 18yrs or older	**Relationship to Patient**