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PATIENT REQUEST FOR RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Full Name: _____ Today's Date: _____

Patient Address: _____ Date of Birth: _____

You have the right to request that we not use or disclose your protected health information (PHI) for treatment, health care operations or any other purpose **except** when specifically authorized by you, when required by law or in emergency circumstances. We will consider your request and respond within 30 days, but are not legally required to accept your request. You also have the right to restrict the release of your PHI to your health plan when paying out of pocket and in full. This does not apply if you ask your health plan to reimburse you for services. Your health plan may request information from our office about your treatment or diagnosis in order to cover your medications. Signing this restriction will inhibit us from giving your health plan that information and may result in non-coverage of treatment or medications. Your health plan may also request information from your pharmacy and you will need to contact them separately.

Please consider this a request to exercise my rights under federal and state law to request confidential communication of my personal health information.

Explain specifically how you want the use of your PHI restricted **AT THIS PRACTICE ONLY:**
What information do you want restricted?

Who is restricted from accessing this information?

Explain specifically how you want the use of your PHI restricted from **DISCLOSURE TO OUTSIDE ENTITIES, INCLUDING YOUR HEALTH PLAN:**
What information do you want restricted?

Who is restricted from accessing this information?

I understand that the provider to whom I am making this request will provide reasonable efforts to accommodate this request. I understand that the provider is not required to honor this request when information is needed about me for emergency treatment or in various instances when the information is permitted by law to be released. I further understand that the provider may terminate this restriction and I will be notified of the termination. I understand that I may also choose to terminate this restriction and may do so orally or in writing.

Patient Signature: _____ Date: _____

Date	Action	Initials	Notes
	Request Received		
	Request Granted		
	Request Denied		Reason for Denial:
	Denial in Writing Sent to Patient		(Attach Copy)
	Request Terminated by Patient		
	Request Terminated by Provider		
	Patient Notified of Termination		(Attach Copy)

Patient Name: DOB: