Request for Restriction on Use or Disclosure of PHI

Our practice will use or disclose your health information for purposes of providing treatment to you, obtaining payment for that treatment, running the operations of our office or as required by other laws. We will disclose your information to others only to the extent they are involved in your care or payment for that care. You can read more about this in our Notice of Privacy Practices.

You have the right to request that we not use your health information for purposes of treatment, payment or operations as described above. Our practice must accept some types of restrictions but have the right to refuse others. We will respond in writing to this request.

Complete this form to request that our practice restrict the use or disclosure of your health information for purposes of treatment, payment or operations that would otherwise be allowed under HIPAA regulations. Please discuss this request with your provider to be sure we both understand the implications of such a restriction.

Practice Name _____

Address _____

_____

Patient Name: _____ DOB: _____

Patient Address: _____

City-State, Zip: _____

Requestor (if other than patient): _____

Legal Authority of Requestor: (attached necessary documentation such as power of attorney) _____

Home Phone: _____ Work Phone: _____

Provide detailed information about the Requested Restriction: (attach an additional page if more room is needed for description)

☐ Do not release information to my insurance provider to obtain payment for medical services or treatment received as described.

- Full payment has been made on behalf of the patient for this treatment/service.
- The implications of this decision have been explained.

Information to be restricted _____

_____

_____

Restriction will apply to the person or entity named (indicate entity such as name of insurance company, name of person involved in your care that the restriction may apply to, etc.) _____

_____

Reason for Request: _____

_____

_____

_____

I understand this request will be considered by the practice and I will be notified in writing of the decision to accept or not accept the restriction as described. I have discussed this request with my provider.

_____ _____

Patient or Personal Representative Signature Date

For Internal Office Use Only:

- ☐ Date request Received
- ☐ Date Patient Notified
- ☐ Request Accepted
- ☐ Alternate Solution Accepted
- ☐ Patient Record Updated
- ☐ Date request resolved
- ☐ Patient Notification Attached
- ☐ Request Denied
- ☐ Alternate Solution Rejected
- ☐ File Copy Retained

Reason for decision: _____

Parties reviewing and concurring with decision _____

_____

_____

Alternate solution suggested _____

_____

_____