REQUEST FOR RESTRICTION ON USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________________ Date of Birth: ________________

Patient Address: ____

Patient Social Security Number: _____________________

I hereby request restrictions on the use and/or disclosure of my protected health information maintained or created by the District.

REQUESTED RESTRICTION: Check the box to indicate the type of restriction and then described the specific restriction.

Note: Even if a requested restriction is granted, it cannot prevent complete disclosures, nor will it prevent disclosures required by law. Disclosures also may be made in case of emergency.

☐ Treatment: ____

☐ Payment: ____

☐ Health Care Operations: ____

☐ Disclosures to a family member or others involved in my care or payment for my care:

____

My request applies to: (check one and indicate date/s)

☐ Communications/ documentation about this date of service only (indicate date): ________ or

☐ From this date of service (indicate date): _______________ until I indicate otherwise, or

☐ From this date: ______________ to this date: _______________

Signature: _______________________________ Date: ____________
(Patient or Personal Representative)

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE:

Type of authority (e.g., court appointed, custodial parent): ______________________________

☐ REQUEST APPROVED

☐ REQUEST DENIED**
- ☐ Too expensive to accommodate request
- ☐ Administratively impractical*
- ☐ May prevent effective treatment
- ☐ Other: ________________________________

By: ________________________________ _______________________ __________________
Signature Title Date

**May not deny the request if the request applies to restricting disclosure to a health plan and the disclosure pertains to a service for which payment in full for out-of-pocket amounts due to the provider has been made.

FILE IN PATIENT RECORD