Patient Name (Print)	Date of Birth	MRN (Facility)
Address	Home Phone Number	Work Phone Number

Please select from the following choices (a separate form should be completed for each request):

☐ You have the right to request in writing limits to how your health information is used or shared regarding **payment**. We **are required** to agree to your request **if it involves restricting access to your health information by your health plan and you pay for that service in full and out of pocket in advance**, or for **health care operations**. **Please note:** this request will be in effect from the date indicated below until we receive a written or verbal notice from you to stop the restriction.

☐ You have the right to request in writing limits to what details of your health information are being shared with someone who is involved in your care and treatment, such as a family member. We **are not required** to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. **Please note:** this request (if accepted) will be in effect from the date indicated below until we receive a written or verbal notice from you to stop the restriction.

Please complete the requested information (print legibly)**:**

Specify the health information regarding payment or health care operations you want to restrict
(include date of encounter / admission date / service provided / health care item):

1.

2.

3.

4.

5.

To whom do you want the limitation(s) to apply (example: name of insurance company, your spouse, a provider):

I understand that the facility may terminate this agreement if:

- I agree to or request the termination in writing;
- I verbally agree to the termination and the verbal agreement is documented;
- The Facility informs me that it is terminating its agreement to a treatment or health care operations restriction. Such termination is only effective with respect to protected health information created or received after the facility has informed me of the termination and does not affect restrictions in place regarding payment.

Patient Signature or Authorized Party	Date	Time

Relationship of Authorized Party

FACILITY USE ONLY

☐ Your request has been granted.
☐ Your request has been denied for the following reason(s):

_____

_____

Facility Representative Signature	Date	Time

Request for Restriction of Use and Disclosure of Health Information

White: Director, Health Information Management
Yellow: Patient