



**Request for Restrictions on Use/Disclosure of PHI for Treatment, Payment and Health Care Operations**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

MRN# of Patient: \_\_\_\_\_

I am requesting a restriction on the use/disclosure of my health information in the manner described below. I understand that the University Health System may deny this request for any reason. If my request is approved, I understand that the restriction will not apply in case of an emergency. A patient or patient's legally authorized representative may not revoke a disclosure that is required for purposes of making payment to the hospital for health care provided to the patient.

Description of Specific Health Information to be Restricted: \_\_\_\_\_

Persons/Organizations Restricted from Use/Disclosure: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Personal Representative (if applicable): \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

*When complete, forward to Medical Records Director for determination.*

Date Request Reviewed: \_\_\_\_\_

Request is:     Approved     Denied

Reason for Denial: \_\_\_\_\_

Final Action Taken: \_\_\_\_\_

Medical Records Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Position/Title of Reviewer: \_\_\_\_\_