University Health System
4502 Medical Drive
Medical Records Department MS# 26-2
Phone: (210) 358-3532 San Antonio, Texas 78229-4493 Fax: (210) 358-5936

REQUEST FOR RESTRICTIONS ON USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Identifying Info: ( ) / /
Phone Number Date of Birth MRN

University Health System will accept for review written requests for certain restrictions on its Use and Disclosures of your Protected Health Information ("PHI") including restrictions on Uses or Disclosures for Treatment, Payment, and Health Care Operations and restrictions on Disclosures to persons involved in your care, such as family or friends. University Health System is not required under federal or state law to agree to abide by any requested restriction. In accordance with federal regulations, requests for restrictions will also not affect University Health System Use or Disclosure of PHI in certain circumstances such as disclosures for public health activities, to report victims of abuse, neglect or other violence, to the federal or state health departments, or for law enforcement or judicial purposes.

1. I hereby request the following restriction(s) on the **internal** Use of my PHI by University Health System in connection with my medical treatment, payment or other health care operations: _____

2. I hereby request the following restriction(s) on the **external** Disclosure of my PHI to third parties by University Health System in connection with my medical treatment, payment or other health care operations: _____

3. I understand that University Health System and its members are not required to agree to my requested restriction(s). I further understand that University Health System will not agree to a restriction that prevents uses or disclosures permitted or required as described in the Notice of Privacy Practices.

4. I understand that even if my requested restriction is accepted, University Health System may use or disclose restricted information if such information is necessary to provide me with emergency treatment.

5. I understand that University Health System may terminate an agreed upon restriction, in which case the termination is effective only with respect to PHI created or received after the date that University Health System notifies me of the termination. I further understand that I may terminate an agreed upon restriction in writing and orally.

6. I understand that I may restrict the disclosure of health information to a health plan; pertaining solely to a healthcare item or service only when I, or someone on my behalf other than the health plan, have paid out-of-pocket in full.

_____ _____ _____
Signature of Patient or Representative Relationship to Patient Date

FOR UNIVERSITY HEALTH SYSTEM ONLY

Restriction Received ☐ in writing **OR** ☐ verbally on date _____ by Employee ID: _____

Restriction has been: ☐ Accepted ☐ Denied **If denied, reason for denial:** _____

_____

Final Action Taken: _____

_____

HIM/Medical Records Director Signature: _____ Date: _____