University Health System
Surgery Center – Robert B. Green Campus
Surgery Center – Medical Center

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

Phone: (___)_____ **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.

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

FOR UNIVERSITY HEALTH SYSTEM USE ONLY **DATE RECEIVED**_____

Restriction has been: ☐ Accepted ☐ Denied

If denied, reason for denial: _____
_____
_____

Final Action Taken: _____
_____

HIM /Medical Records Director Signature: _____ Date_____