REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Resident Name: _____

Medical Record No: _____

Address:_____
_____

Directory Information Restriction: I request that the disclosure of my information maintained in the Facility directory be restricted in the following manner:

_____Do not include my name, location, general condition or religious affiliation in the Facility directory.
_____Do not disclose my name or religious affiliation to members of the clergy.
_____Do not disclose my location in the building to:_____.
_____Do not disclose my general condition to: _____

_____ _____
Signature of Resident or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Other Restrictions: I request the following restriction(s) on the use or disclosure of my Protected Health Information:

_____Do not release information to the following person(s)

_____

_____

Other restriction (please specify):

_____

_____

_____ _____
Signature of Resident or Personal Representative Date

_____
Print Name

_____
Personal Representative
Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney

THE FACILITY RESPONSE:

_____Your request for restriction has been declined.

Note: The Facility may not deny a request for restriction of Directory Information.

_____Your request for restriction has been accepted. In the case of an emergency or if necessary to comply with the law, we may use and disclose your health information in violation of the restriction. Other than in those circumstances, we will abide by your request unless and until the restriction is terminated (with or without your agreement) and you are notified.

_____ _____

Signature of the Facility Privacy Official Date

_____

Print Name

TERMINATION OF RESTRICTION

_____The above-named resident agreed to terminate this restriction on: _____.

_____The above-named resident was notified on _____ (date) that this restriction was terminated.

- Resident was notified: (check appropriate box)

  _____In person

  _____By telephone (attach documentation of notification)

  _____By mail (attach documentation of notification)

_____ _____

Signature of the Facility Privacy Official Date

_____

Print Name

Distribution of copies: Original to resident's Medical Record; copy to resident.