Request To Consider Additional Privacy Protection For
Protected Health Information – Attachment A

Date of Request: 01/26/2026	Date of Birth: 08/14/1987	U #:

Patient Name:
Collin Blaine George

Patient Address:

17411 ne 45th St. #167 Redmond, WA 98052

Provide Detail For This Request For Additional Privacy Protection (Include **Why**, **What**, and, **To Whom** below). Please be specific as to which individuals or entities will be denied or limited in use and/or disclosure:

Why: To minimize my digital footprint and ensure the security and confidentiality of my Protected Health Information (PHI) under HIPAA (45 CFR § 164.522(a)) and the Washington My Health My Data Act.

What: A formal 'Break the Glass' restriction on my entire medical record (including Oncology, Primary Care, and Behavioral Health). I request that a prompt be required for any staff member attempting to access my record, requiring a documented justification for each instance of access.

To Whom:I request that access be strictly limited to my immediate treatment team, specifically Dr. Linda Van-Hoff and Dr. Maria Ghuizeli. I explicitly deny use and disclosure to any other staff, residents, administrative personnel, or third-party business associates unless it is for the immediate purpose of emergency life-saving treatment or required by law.

_____   01/26/2026

 Signature of Patient or Legal Representative (relationship to patient)   Date

NOTE: If the request is approved, SCCA will make reasonable efforts to comply with the restriction.

For SCCA Use Only: Submit to Corporate Integrity at LG-600 or Fax: 206-288-1321

Sections 1, 2, & 3 Must Be Completed By Corporate Integrity
Section 4 Must Be Completed By HIM

1. Date Received:	2. Received By:

3. Restriction Has Been Approved and Communicated to Patient Care Team.

Signature/Date:_____

4. HIM Documented Restriction In Medical Record and EPIC/Cadence Permanent Comments.

Signature/Date:_____