INTEGRIS

PATIENT REQUEST TO RESTRICT / LIMIT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTICE: The Privacy Rules allow you to request restrictions on the use and disclosure of your protected health information ("PHI"). Please complete this form to describe the restrictions or limitations you are requesting. Generally, we are not required to honor your request unless stipulated by law, with one exception. INTEGRIS must comply with the requested restriction if: (i) the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), except as otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which INTEGRIS has been paid out of pocket in full prior to the performance of the service. Otherwise, if we agree to honor it, we will comply with your request unless the information is needed to provide emergency care to you.

Patient Name: _____ **Date of Birth:** _____

Address: _____
Street **City** **State** **Zip**

Phone: _____ **Medical Record Number:** _____

I request the following protected health information ("PHI") be restricted from disclosure:

_____

_____

I wish to limit or restrict release of my PHI to the following individuals or entities:

_____

_____

The purpose for limiting or restricting disclosure of my information is:

_____

_____

Understanding and Acknowledgment

I acknowledge that an explanation of how my PHI is used and disclosed has been provided to me. I understand that INTEGRIS may refuse to honor my request to restrict / limit disclosure of my PHI unless required by law. I understand that I may revoke this request at a future date by signing the Revocation statement below.

_____ _____
Signature of Patient Date

Revocation of Patient Request to Limit / Restrict Disclosure of PHI

I revoke this request to limit / restrict disclosure of my PHI effective with the date indicated below.

_____ _____
Signature of Patient Date

For Facility Use Only:

_____ Date Accepted:_____ Date Denied:_____
Signature of Authorized Provider Representative