



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: _____

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 _____

The completed form may be faxed to INTEGRIS Health Information Management at 405-552-8773, mailed to 3433 NW 56th Street, Bld. B Ste. C50 Oklahoma City, OK 73112, or emailed to Healthinfomanagement@integrishealth.org. For questions, call 877-778-7211.

Patient Label
Patient Name:
MRN:
DOB:

INT-1672 Release of Information Forms



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