Nemours.

*1001188*

Patient Name:
MRN:
DOB:

# Request for Restriction on Uses & Disclosures of Protected Health Information

**Please complete the following information:** **Date:** _____

**Patient's Address:** _____

1. **Date(s) of Encounter to be held as Restricted:** _____
2. **Type of Encounter(s) to be held as Restricted:** _____
3. **Listing of Ancillary Service(s) to be held as Restricted:** _____
4. **From whom should this information be restricted:** _____

| | List Specific Tests/Encounters | List the Date of the Tests |
|---|---|---|
| ☐ **Clinical (Lab) Test:** | _____ | _____ |
| ☐ **Medical Imaging (x-ray)Test** | _____ | _____ |
| ☐ **Behavioral Health Reports** | _____ | _____ |
| ☐ **Therapy reports** | _____ | _____ |
| ☐ **Other** | _____ | _____ |

5. **Name of the Healthcare Provider(s) who was seen at the time of the Encounter:**
   _____ _____
   _____ _____

I understand that I have the right to request that Nemours restrict their use and disclosure of my protected health information (PHI). This means that I may ask Nemours not to use or disclose any part of my PHI for purposes of treatment, payment, or health care operations. I may also request that any part of my PHI not be disclosed to family members or friends who may be involved in my care. I also understand that Nemours is not required to agree to the restriction that I request.

I understand that Nemours must agree not to disclose my PHI to my health plan if the disclosure is for payment or health care operations and relates to a health care item or service, which I paid for in full, out of pocket. I also understand that if Nemours agrees to the requested restriction, Nemours may not use or disclose my PHI in violation of the restriction unless it is needed to provide emergency treatment or the law mandates such use or disclosure. Finally, I understand that I can terminate the restriction at any time, in writing, and that Nemours can terminate this agreement upon written notification to the patient or Legal Representative.

| _____ | _____ | _____ | _____ AM |
|---|---|---|---|
| **Patient / Legal Representative's Signature** | **Print Name** | **Date** | **Time** PM |

**INTERPRETER'S SIGNATURE:** (To be completed only when appropriate)

I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

| _____ | _____ | _____ | _____ AM |
|---|---|---|---|
| Interpreter's Signature &/or Telephone Identification Number | Print Name | Date | Time PM |

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including The Alfred I. duPont Hospital for Children Surgery Center, Bryn Mawr and Alfred I. duPont Hospital for Children Surgery Center, Deptford; and all entities operating under the name Nemours duPont Pediatrics.

Nemours.

Patient Name:
MRN:
DOB:

# Request for Restriction on Uses & Disclosures of Protected Health Information

## To be completed by Nemours

**Restriction has been:** ☐ **Accepted** ☐ **Denied (If denied, check the reason for denial):**

- ☐ **Upon recommendation of the Health care Provider**
- ☐ **Upon recommendation of the Operational Review Team**
- ☐ **Federal/State law prohibits the restriction**

**Comments by the Healthcare Provider:**

_____

_____

_____

_____

_____

**Comments by the Operational Review Team:**

_____

_____

_____

_____

_____

**Request for Restriction has been reviewed by the following:**

| _____ | _____ | _____ | _____ AM |
|---|---|---|---|
| **Reviewer's Signature** | **Please Print Name** | **Date** | **Time PM** |
| _____ | _____ | _____ | _____ AM |
| **Reviewer's Signature** | **Please Print Name** | **Date** | **Time PM** |

**Notification was sent to:**

| | **Who received notice** | **Date Sent** |
|---|---|---|
| ☐ **Patient/Legal Representative** | _____ | _____ |
| ☐ **Provider** | _____ | _____ |
| ☐ **Scheduling** | _____ | _____ |
| ☐ **Central Billing Office (CBO)** | _____ | _____ |
| ☐ **Medical Imaging** | _____ | _____ |
| ☐ **Clinical Lab** | _____ | _____ |
| ☐ **Other** | _____ | _____ |

| _____ | _____ | |
|---|---|---|
| **Signature of Staff Member** | **Please Print Name** | |
| _____ | _____ | _____ AM |
| **Please Print Title** | **Date** | **Time PM** |