Nemours.

Request for Restriction on Uses & Disclosures of Protected Health Information

01006-1

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

Patient's Name: _____

Patient's Address: _____

Date of Birth: _____ **Patient MR#:** _____

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/encounter	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 HIPAA Privacy Standards provide an individual with the right to request a restriction on Uses and Disclosures, but the covering entity, Nemours, is only required to permit the request. If Nemours agrees to the requested restriction, Nemours may not make use or disclose that which is inconsistent with such restrictions, unless law mandates such uses or disclosures.

I understand that I can terminate the restriction at any time in writing. I also understand that Nemours can terminate this agreement upon written notification to the patient/legal representative. Such termination is only effective with respect to protected health information created or received after it has so informed the individual.

_____ _____

Date **Patient/Legal Representative**

_____

(To Be Completed Only When Appropriate)

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

_____ _____

Date Signature of Translator

Nemours.

01006-2

Patient Name: _____

MR#: _____

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:

_____	_____	_____
Date	**Please Print Name**	**Signature**
_____	_____	_____
Date	**Please Print Name**	**Signature**

Notification was sent to:

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

_____ _____

Date **Signature of Staff Member**

_____ _____

Please Print Title **Please Print Name**