Request to Restrict the Use and Disclosure of Protected Health Information

Name of Resident:____ Date: ___________________________

I request that you restrict the use and disclosure of my protected health information as checked below:

[ ] Do not release my health information if the uses or disclosures of my health information are to carry out treatment, payment or health care operations.

[ ] Do not disclose my health information, my location, or my death to the family members, friends, or relatives I have named below:

____ ____

____ ____

____ ____

[ ] Do not include my name in the Facility Directory.

[ ] Do not disclose my name or health information for the purposes of fundraising or marketing.

Acknowledgment of Conditions of Restrictions

I hereby acknowledge the following conditions of my requested restrictions concerning the use and disclosure of my protected health information:

- ✓ I understand that the facility has sixty (60) days from the date of this request to respond to my request unless I am provided with a notice that an extension is necessary. I understand the extension may not exceed thirty (30) days.
- ✓ I understand that the facility is **not** required to agree to this request for restriction of my health information and that I will be notified in writing of any denial of such requests as well as how I may appeal any such denial.
- ✓ I understand that the facility's agreement to honor a part of my request does not mean that the facility agrees to all of my restriction requests.
- ✓ I understand that if the facility agrees to honor my request, or any part of my request, such restrictions will remain in effect until I agree in writing to revoke the restriction or until the facility notifies me in writing that it is terminating this agreement.
- ✓ I understand that should the facility terminate this agreement, the use or disclosure of my protected health information will only apply to information created or maintained **after** the date of this request.
- ✓ I understand that this agreement does not apply to the release of my health information for emergency treatment situations but the facility will request that the organization or individual receiving such information honor my request not to use or disclose such information to others.
- ✓ I understand that this agreement does not apply if such release of information is required by law.
- ✓ I understand that this agreement does not apply under certain public health activities (e.g., obligations of the facility to report certain infectious diseases, injuries, or death).
- ✓ I understand that this agreement does not apply in the reporting of my health information to law enforcement officials or state agencies relative to abuse, neglect, violence, or other crimes.
- ✓ I understand that this agreement does not apply when use or disclosure of my health information is to a health oversight agency (such as a state survey agency), for a law enforcement investigation proceeding, a judicial or administrative proceeding, certain research activities, or to coroners or funeral directors for the purpose of identifying a body or determining the cause of death.
- ✓ I understand that the facility may inform other individuals, organizations, and entities about the existence of my restrictions, as long as such action does not disclose any health information about me.
- ✓ I understand that any agreed upon restrictions are binding only for this facility and will not apply to any of the facility's business associates.
- ✓ I understand that I may revoke this request at anytime by providing the facility with my written notice of such revocation.

Date: _________________ Signature of Resident: ___________________________________ Printed Name: _______________________________

Date: _________________ Signature of Representative: ______________________________ Printed Name: _______________________________

Relationship to Resident: ________________________________

Facility Response to Request

The facility agrees to accept [ ] All of your requests [ ] Only the following requests:____

____

____

[ ] Your request is **DENIED** based on the following reasons:____

____

You may file an appeal of this denial with ____________________________________ who is located at ______________________________________

and can be reached by telephoning ____ .

Date: _________________ Signature/Title of Authorized Facility Representative:____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.