

DT159805

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**REQUEST FOR RESTRICTION ON THE USE OR
DISCLOSURE OF YOUR HEALTH INFORMATION**

You have the right to request that MHCS restrict the use and disclosure of your health information for certain aspects of treatment, payment, or our health care operations (See our Notice of Privacy Practices for more information on these types of uses and disclosures). You also have the right to request that MHCS restrict the disclosure of your health information to family members and other people involved with your care, payment for your health care, or for notification purposes to others outside of MHCS.

MHCS will evaluate your request and determine if it is reasonable and in the best interest of your health care to comply with the request. MHCS will notify you in writing of our determination whether or not to grant your request. If your request is granted and you are in need of emergency treatment, we may end the restriction if the information is needed to provide your care.

Date of Request: _____

Patient's Name: _____ Date _____ of
Birth: _____

Patient Address

Phone #

The restriction is requested for the health information checked below:

- | | |
|-----------------------------|-------------------------------------|
| Social Security Number | Date of admission |
| Admitting diagnosis | Date of discharge |
| Laboratory data | Letters of diagnostic tests |
| Reports of diagnostic tests | Listings of medications |
| Listings of treatments | Information from physician consults |

Other Information: _____ Health

Do not provide the health information checked above to the following person(s) or organization:

Names: _____

Reason Restriction: _____ for

Signature: _____ Date: _____

For Internal Use Only

Date form received: _____

Restriction: Approved _____ Denied
Reason: _____

Name and title of the Staff member who received, approved or denied the request:

Name and title

Phone number

