CHI Memorial

Imagine better health.℠

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

Copy of Patient Identification Required

You have the right to request that CHI Memorial 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). Some state laws and government payers, such as Medicare and Medicaid, may require that CHI Memorial bill and receive cash payments from a patient for services over and above any permissible cost sharing amounts. In such circumstances CHI Memorial may deny your request for restriction as they must comply with applicable laws.

You also have the right to request that CHI Memorial 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 CHI Memorial.

CHI Memorial will evaluate your request and determine if it is reasonable and in the best interest of your health care to comply with the request. CHI Memorial 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:

____

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

Names: ____

Reason for Restriction: ____

Signature: ____ Date: ________________________

For Internal Use Only

Date form received: __________________

Restriction: ❑ Approved ❑ Denied Reason: ____

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

____ Phone number: _________________________