REQUEST FOR RESTRICTION OF USES AND DISCLOSURE OF PHI

SUNCOAST ORTHOPAEDIC SURGERY & SPORTS MEDICINE

This form is to be used by patients who wish to request a restriction of the uses and disclosures of their protected health information (PHI). Patients or authorized individuals are only allowed to request a restriction of the uses and disclosures pertaining to treatment, payment, or health care operations in accordance with 45 CFR § 164.522. Any other uses or disclosures are required by law and can not be altered by our practice. By law our practice is required to agree to a requested restriction except for treatment purposes when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. We will not use or disclose your protected health information in violation of such restrictions, except that, if the individual who requested the restrictions is in need of emergency treatment and the restricted protected health information is needed to provide the emergency treatment, our office may use the restricted protected health information, or may disclose such information to a health care provider, to provide such treatment to the individual. If our practice does disclose protected health information to another health care provider for emergency treatment, we will request that the receiving health care provider will not further use or disclose the information. Any restrictions agreed upon by our practice shall not prevent uses or disclosures to the Secretary of Health and Human Services for compliance reasons, or any other disclosure that is require by law.

Requested Restriction

Please describe the restriction: _____

_____

_____

_____

_____

_____

Terminating this Restriction

Our practice may terminate this agreement to a restriction if:

- You agrees to or requests the termination in writing
- You orally agree to the termination and the oral agreement is documented, or
- Our practice informs you that we are terminating the agreement. We will only be able to use or disclose protected health information that is created or receive after the restriction agreement is terminated (nothing under which the agreement was active).

_____

Name of Patient (Type or Print)

_____

Signature of Patient Date

❑ **We hereby accept the above restriction of PHI.**

❑ **We hereby deny this request for restriction of PHI.**

_____

Compliance Officers Name (Type/Print)

_____

Compliance Officer Signature

_____

Date

Provided by HCP