MetroHealth

REQUEST FOR RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Medical Record Number: _____

Address: _____

Phone Number: _____

I am requesting a restriction on the use and disclosure of my protected health information in the manner described below. I understand that The MetroHealth System (MHS) may deny this request. I understand that, if accepted, MHS will document this restriction to the best of its ability within the records controlled by MHS. If my request is accepted, I understand that the restriction will not apply in case of an emergency. This request will be effective indefinitely unless otherwise indicated.

☐ The restriction(s) I am requesting are for episodes of care paid for by me out of pocket prior to today.

OR

☐ The restriction(s) I am requesting pertains to my episode of care occurring today. I understand that I am financially responsible for the balance of this episode of care pursuant to MHS usual billing practices.

Dates of Specific Health Information to be Restricted: _____

Specific Conditions to be Restricted:

Health Plan Restricted from Use/Disclosure: _____

Patient Signature: _____ Date: _____

Name of Personal Representative (if applicable): _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

Send completed form to HIPAAprivacy@metrohealth.org, fax to (216) 778-8777, or mail to The MetroHealth System, Attn: Privacy, 2500 Metrohealth Drive, Cleveland, OH 44109

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For MHS use only:

Date Request Reviewed: _____

ICD-10 diagnosis code(s) family (first three digits) for restriction: _____

Position Titles of Reviewers: _____

Request is: ☐Approved ☐Denied Reason for Denial: _____

Final Action Taken: _____

Flagged in electronic record: ☐ Completed

Privacy Officer's/Designee's Signature: _____ Date: _____