Privacy Forms

Saint Luke's Health System

Request for Health Plan
Patient Health Information (PHI) Restriction

Complete this form and submit to the health care facility.

I am asking for restricted disclosure of PHI to my health plan. I have been given information concerning this restriction and will comply with all requirements.

I understand that payment must be paid in full at the time of service. Any additional charges must be paid within 30 days of the billing date. Failure to pay any billed account balance in full within the 30 days may result in SLHS filing a claim to a designated health plan or to a 3rd party for collection.

Account #:_____ **Date of Service:**_____

Print Patient Name:_____ Date of Birth:_____

Signature of Patient:_____ Date:_____ Time:_____
(or Legal Representative)

Relationship to Patient:_____

Contact phone number:_____

For Organizational Use Only

☐ Request Approved Date:_____ Time:_____

Signature of Employee/Witness:_____

Facility Name:_____ Contact Phone Number:_____

☐ Copy to Privacy Site Coordinator Date:_____ Time:_____

Patient Label: