Privacy Forms

Saint Luke's Health System

General Request for Limitations and/or Restrictions on Uses and Disclosures of Protected Health Information

Please Return Form to: SLHS Privacy Office at 901 E. 104th St., Kansas City, MO 64131 or via email at privacy@saintlukeskc.org.

While it is unlikely, there is a possibility that unsecure email could be intercepted and read by other parties besides the person to whom it is addressed. By sending your request by email, you are agreeing to accept these risks.

Patient's Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Phone Number:** _____

Date of Request: _____ **Account #/MRN (if known):** _____

Describe the Restriction: _____

_____

_____

_____

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_____

_____

You have the right to request a restriction on our uses and disclosures of your information for the purposes of treatment, payment, and health care operations. You may also restrict disclosures we make to family members or others involved in your care or in payment of your care. We are not required to agree to your request. If the request is approved, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request, we will notify you in writing.

By submitting this form, I hereby request the organization to restrict uses and disclosures of my health information as described above. I understand and acknowledge that the organization is not required to agree to my request.

_____
Signature of Patient or Legal Representative

_____ **to** _____
Date Notice Effective Date Notice Expiration

_____
Relationship to Patient (if signature other than patient)

Original: Privacy Staff send to HIM to File in Medical Record