Privacy Forms

Saint Luke's Health System

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

Complete this form and submit to the Privacy Site Coordinator or Health Information Management Dept.

1. **Patient's Name:** _____
2. **Address:** _____

   City: _____ **State:** _____ **Zip:** _____
3. **Date of Birth:** _____ **Phone Number:** _____
4. **Date of Request:** _____ **Account #/MRN:** _____
5. **Describe the Restriction:** _____

   _____

   _____

   _____
6. 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.
7. 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.

_____ _____ **to** _____

Signature of Patient or Legal Representative Date Notice Effective

_____

Relationship to Patient (if signature other than patient)

FOR ORGANIZATIONAL USE ONLY

REQUEST: ☐ APPROVED ☐ Denied ☐ Not Applicable ☐ Approved w/ changes noted below

Notes: _____

_____

Requester Notified: ☐ Yes ☐ No On Date: _____

Signature of Reviewer: _____ Date: _____ Time: _____

Original: PSC to File in Medical Record