Saint Luke's Health System

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

Please Return Form to: Any Medical Record Department or the SLHS Privacy Office at 901 E. 104th St., Mailstop 3000-S, 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:**______________________

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. <u>We are not required to agree to your request.</u> 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.

____________________________________ ______________ **to** ______________

Signature of Patient or Legal Representative Date Notice Effective

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Relationship to Patient (if signature other than patient)

FOR ORGANIZATIONAL USE ONLY

REQUEST: ☐ APPROVED ☐ Denied ☐ Not Applicable ☐ Approved with changes noted below

Notes:____

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Requester Notified: ☐ Yes ☐ No On Date:______________

Signature of Reviewer:______________________________ Date:__________ Time:__________

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