REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____

Your Name: _____ Date of Birth: _____

I understand that Adventist Health may use or disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations. AH may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend, under certain circumstances.

I hereby request a special restriction on the hospital's use or disclosure of protected health information.

The information I want limited is:

_____

_____

_____

_____

I want to limit:

☐ The hospital's use of this information.

☐ The hospital's disclosure of this information.

☐ Both the use and the disclosure of this information.

I want the limits to apply to the following person/entity (for example, a spouse):

_____

_____

I understand that AH does not have to agree to my request, unless I am requesting a restriction on disclosure of information to a health plan for payment or health care operations purposes, and I have (or someone on my behalf other than the health plan has) paid for the item or service out of pocket in full. The hospital will still be able to disclose this information to the health plan if required by law.

PATIENT ID