Patient Request to Restrict Use or Disclosure of Protected Health Information

Patient Name: ____ Date of Birth: _________________________
Address: ____City/State/Zip Code:______________________________
Telephone # most easily reached: ____

Please check the correct box:

☐A. I request that All Med Physicians restrict the use or disclosure of my health information **to my health plan** as follows:

Describe the information you want restricted including specific date of service(s):

____
____
____

Note- this restriction is only valid for items or services paid for out of pocket in full at the time the service is rendered.

☐B. I request that All Med Physicians restrict the use or disclosure of my health information as follows:____
____
___

____
____
____

I understand that the information in my medical record may include information relating to sensitive information. State and federal laws protect this sensitive information. If the information applies to you, **please check the information you would like to be restricted**. Provide date(s) if appropriate.

_____Alcohol, drug, or substance abuse records: Dates: ____________________

_____AIDS, HIV testing/results: Dates: ____________________

_____Mental health records: Dates: ____________________

_____Sexually Transmitted Disease records: Dates: ____________________

_____Genetic records: Dates: ____________________

_____Research records: Dates: ____________________

Patient Request to Restrict the Use or Disclosure of Protected Health Information

By signing this authorization form to restrict the use or disclosure of my medical information, I understand that:

- **Restrictions to a health plan** are only valid for items or services that have been paid in full, out of pocket. All Med Physicians will not submit a claim to the health plan for services that you have paid in full at the time the service was provided. I need to notify the Patient Service Representative (PSR) when presenting for the visit that I wish to restrict use or disclosure of my information to the health plan, pay for the service(s) in full ("Self-pay"), complete the information requested under "A" above and return it to the PSR at that time. I understand that All Med Physicians will grant requests for restrictions to health plans only if the service has been paid in full.
- **Restrictions to individuals (family members or others) or other entities (excluding health plans)** require completion of the form, as applicable. All Med Physicians will review the information to determine whether or not the request will be honored and notify me within 60 days from receipt of the request for restriction.
- I have the right to revoke or modify the restriction at any time. The request must be made in writing and presented to the applicable All Med Physician medical office or mailed to the Director of Health
- Restrictions will not apply to information that has already been used or disclosed as part of All Med Physicians' treatment, payment or operations or pursuant to previous authorizations from me to the individuals and/or entities identified at the time this form is completed.
- Unless otherwise revoked or modified, this restriction will expire on the following date/event/ condition: ________________________________. If I fail to specify an expiration date/event/ condition, this authorization will expire 6 months from the date signed. Restrictions to health plans do not expire unless I revoke or modify the restriction.
- I understand that signing this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Signature Patient or Authorized Representative:__________________________________

Date:________________________

Print Name of Patient or Authorized Representative:_______________________________

Relationship to Patient or Authority of Authorized Representative:____________________

For All Med Use Only
Date Received: (MO/DY/YR) ____/____/____

Received by (print):_______________________________

Scanned to HIM by Medical Office

Disposition of Request: _____ Granted ____Denied (Notify Requestor)
Reason for Denial:

____

If request denied, Requestor notified (MO/DY/YR) ___/___/_____