PeaceHealth

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION - VIF

(This page goes to patient - Do not scan into record)

Patient Identification

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

To our patients:

Under federal privacy regulations you have the right to request restrictions on how your health information is used and disclosed. Here are some things you should know about this right and how PeaceHealth administers it:

- Except for restrictions on disclosures to your health plan as described below, PeaceHealth is not required to comply with your request for a restriction.

- PeaceHealth is required by law to disclose patient information *without your written authorization,* to a variety of state, federal, and other entities for a variety of purposes (see the PeaceHealth Joint Notice of Privacy Practices for a complete description). We cannot comply with a request to restrict all disclosures or to obtain your authorization prior to disclosing any of your health information

- Generally speaking, PeaceHealth will not agree to comply with a restriction unless we can be absolutely confident that we will be able to adhere to the restriction as requested. Many restriction requests are denied for practical reasons.

- You have the right to request restrictions on disclosures to your health plan for services or items for which you have personally paid in full "out of pocket". PeaceHealth must comply with this type of request. However:

  - You must personally pay in full for the healthcare item or service.

  - If you fail to pay in full, your restriction request is considered invalid and PeaceHealth will submit a claim for reimbursement to your health plan for the item or service.

  - Because inpatient hospital stays are reimbursed by health plans differently from other healthcare services - typically a lump sum payment based on your diagnosis - it is not practical to withhold information about a specific service or item from your health plan. If you wish to restrict a disclosure to your health plan for an item or service provided during an inpatient hospital stay, you must pay in full for the entire hospital stay.

  - If you pay in full for a diagnostic service, such as a lab test or an x-ray exam, and request a restriction on disclosures to your health plan, we will certainly not send your health plan a claim for reimbursement. However, your treating provider may be required to submit the diagnostic results to your health plan in order to be reimbursed for his/her services. You must contact your provider's office directly to request a restriction.

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RSTRICT-ADD

Patient Identification

Patient Information (please print):

LAST NAME	FIRST	MIDDLE
STREET ADDRESS		DAYTIME PHONE
CITY, STATE, ZIP		EVENING PHONE
DATE OF BIRTH	MEDICAL RECORD NUMBER	

I request the following restriction be made for my protected health information:

❑ Uses by, or disclosures to individuals or entities (other than disclosures to my health plan as described below)

INFORMATION TO BE RESTRICTED
INDIVIDUALS WHO ARE TO BE RESTRICTED FROM THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION INCLUDE:
TIME FRAME OF THE RESTRICTION: (FROM) _____ (TO) _____

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❑ Disclosures to my health plan regarding items or services for which I am personally paying in full "out of pocket"

DESCRIPTION OF ITEM OR SERVICE	
DATE(S) OF SERVICE	ACCOUNT NUMBER
❑ Restriction rescinded due to failure to pay in full for services. Date: _____	

I understand that, if I am requesting restriction on disclosures to my health plan, I must pay in full for the specified service(s) or PeaceHealth cannot restrict disclosures of my health information to my health plan.

_____ _____

Signature of Patient or legal/personal representative Date

Relationship to patient/authority: _____

FOR PEACEHEALTH USE ONLY

Routing: Restrictions on disclosures to health plans - HIM; all others to Regional Privacy Officer

❑ Restriction Accepted ❑ Restriction Denied (reason): _____

❑ Patient counseled re: potential effects of restrictions _____

❑ Patient/Personal Representative notified of restriction decision by:

_____

Signature Title EMR# Date Time