

## Restriction of Health Information Request

Patient name	Request date
Street address	Birthdate
City/state/ZIP	MHN

### WHAT NEEDS TO BE RESTRICTED

Explain how you wish us to restrict uses or disclosures of your health information to carry out treatment, payment or health care operations.

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Explain how you wish us to restrict disclosures of your health information to:

- your family member or other person identified by you as being involved in your care or payment for your care
- a person or organization for disaster relief purposes

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I understand that Marshfield Clinic is not required to agree to my request to restrict uses and disclosures of my health information.

Signature of patient or patient's legal representative	Relationship	Date	Phone no.
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<b>FOR MARSHFIELD CLINIC INTERNAL USE ONLY</b>	Date received _____
<input type="checkbox"/> Accepted <input type="checkbox"/> Denied If denied, check reason for denial: <input type="checkbox"/> PHI was not created by Marshfield Clinic <input type="checkbox"/> PHI cannot be restricted for quality and continuity of care reasons <input type="checkbox"/> Request is for restriction of uses or disclosures of PHI for purposes other than treatment, payment or health care operations <input type="checkbox"/> Request is for restriction of disclosures of PHI for other than 164.510(b) purposes	
Comments: <input type="checkbox"/> Individual was informed of denial in writing (attach letter of communication)	
Signature/title of staff member	Date