Patient name			
MHN	DOB	Age	Gender

Restrictions by Patient

Release of Information Request

Request date (month/day/year) _____ /_____ /_____

Patient address _____

City _____ State _____ ZIP _____

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.

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

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

_____ _____ _____ /_____ /_____ _____

Patient signature (Patient's legal representative) (Relationship to patient) Signature date (m/d/y) Phone number

Send completed request to: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

FOR MARSHFIELD CLINIC INTERNAL USE ONLY

Date received (month/day/year) _____ /_____ /_____

☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ PHI was not created by Marshfield Clinic

☐ PHI cannot be restricted for quality and continuity of care reasons

☐ Request is for restriction of uses or disclosures of PHI for purposes other than treatment, payment or health care operations

☐ Request is for restriction of disclosures of PHI for other than 164.510(b) purposes

Comments: ☐ Individual was informed of denial in writing (attach letter of communication)

_____ _____ /_____ /_____

Staff member signature/title Date (month/day/year)

