Marshfield Clinic Health System

Patient Name:	MRN:	DOB:	Sex:

Restriction of Information Request Form

Date of Request _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Phone # _____ Email _____

What Needs to be Restricted and Why

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

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

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

I understand that Marshfield Clinic Health System is not required to agree to restrict uses and disclosures of my health information, as allowed under the federal HIPAA Privacy Rule.

Patient signature _____ Date/Time _____ Printed name _____

Signature of Authorized Person _____ Date/Time _____ Printed name _____

❑ Parent of Minor ❑ Court appointed guardian/conservator - include legal documentation

Mail Form to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
ATTN: Health Information Management, HM2

Fax Form to: 715-389-0564

Email Form to: himroiadmrestrevreq@marshfieldclinic.org

FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY **Date received by HIM** _____ **Date Sent** _____

Status ❑ Accepted ❑ Denied

If denied, select reason for denial:

❑ PHI was not created by Marshfield Clinic Health System

❑ PHI cannot be restricted for quality or continuity of care reasons

❑ Request is for restriction of uses and 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

❑ Individual was informed of denial in writing (attach letter of communication)

Staff member Signature _____ Date/Time _____

Printed name and title _____

