PeaceHealth

Request for Restrictions 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.
    - 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.

Date received by HIM or PFS: _____

Last Name:	First:	Middle:
Street Address:	Phone:	
City, State, Zip:	Date of Birth:	

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) _____

❑ Disclosures **to my health plan** regarding items or services for which I am personally paying in full "out of pocket" (by checking this box, I understand I am financially responsible for the items or services associated with this request).

Description of item or service:	
Date(s) of service:	Account number:

I understand and agree that, if I am requesting restriction on disclosures to my health plan, I must pay in full for the specified service(s).

_____

Signature Patient/Person Authorized to Sign for Patient – Relationship Date Time

FOR PEACEHEALTH use only:

ROUTING: Restrictions on disclosures to health plans - send to HIM: all others to Network Privacy Officer

❑ Disclosure to health plan (insurance) Scan to RST-INS

❑ Restriction Accepted Scan to RST-AD

❑ Restriction Denied Scan to RSTDEN

❑ Patient/Personal Representative notified of restriction decision by:

_____

Signature Title Date Time

Patient Identification