St Luke's

# REQUEST FOR RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, understand that:
*(Patient Name)*

1. There are legal restrictions on the manner in which St. Luke's may use or disclose health information about me.

2. I have the right to request additional restrictions on the way in which St. Luke's uses or discloses my health information, in addition to the restrictions already imposed by law.

3. St. Luke's is not required to grant my request for additional restrictions.

4. If St. Luke's does grant my request for restrictions; the restricted information will not be used or disclosed except to provide treatment to me in an emergency.

5. St. Luke's and I can terminate our agreement to a restriction at any time by notifying the other party. If St. Luke's terminates its agreement to a restriction, it will notify me, and will continue to comply with the restriction for any information that was created prior to the date of termination.

6. I request the following restrictions with respect to my Protected Health Information:

_____

_____

_____ _____
Date Signature of patient (or personal representative)

Request Approved / Request Denied *(must be circled to be in effect)*

_____ _____
Date [Name], Privacy Officer