WVU PHYSICIANS OF CHARLESTON

REQUEST TO RESTRICT USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient to complete the following information.

DATE:_____

PATIENT NAME:_____ BIRTH DATE:_____

PATIENT ADDRESS:_____

PATIENT TELEPHONE NO.:_____ MED. REC. NO:_____

REQUEST:

I hereby request WVUPC to restrict the use and disclosure of the following information **(check all that apply)**:

□ Restrict uses and disclosures of my health information for purposes of treatment, payment, or health care operations in the following way (please explain):_____

_____

□ Restrict disclosures to a family member, relative, or close personal friend who is involved with my health care. Please specify individual(s) to whom disclosures should not be made: _____

_____

□ Other (please explain):_____

_____

PATIENT ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION (Patient to initial each condition)

1. _____ I understand that WVUPC is not required to agree to this request for restriction.
2. _____ I understand that WVUPC may agree to only a part of the request for restriction, while denying agreement to the remaining request.
3. _____ I understand that, if WVUPC agrees to the requested restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:

    a. Patient agrees to or requests in writing that the restriction be terminated
    b. WVUPC notifies patient in writing that it is terminating the agreement to restrict. If patient terminates the agreement to restrict, then the termination is effective only with respect to information created or maintained after the date of the restriction

4. _____ I understand that my restricted health information may be disclosed to provide emergency treatment and that in such circumstances WVUPC will not further use or disclose my restricted health information for any other purpose.
5. _____ I understand that I still have a right to access my health information as allowed under applicable law.
6. _____ I understand that I may receive an accounting of disclosures as explained in WVUPC's Notice of Privacy Practices.
7. _____ I understand that I still must inform WVUPC if I do not want my name on the Patient directory.
8. _____ I understand that my restricted health information may still be disclosed for public policy purposes as stated in the WVUPC Notice of Privacy Practices.

SECTION B: WVUPC Staff to complete the following.

Request for restriction is: □ Accepted □ Denied

Staff comments _____

_____

_____

Signature of staff person _____ **Date** _____

Print name and title _____