Regional Medical Center
MANCHESTER, IOWA (563) 927-3212

Request To Restrict Use and Disclosure of Protected Health Information

Section A: Patient to complete the following information:

Date: _____

Patient Name: _____

Birth Date: _____

Patient Address: _____

Patient Telephone No: _____ Medical Record Number: _____

Request:
I hereby request Regional Medical Center/Regional Family Health to restrict the use and disclosure of the following information (check all that apply)

☐ Restrict uses and disclosures of health information for purposes of treatment, payment, and health care operations.

☐ Restrict disclosures to a family member, relative or close personal friend who is involved with my health care, including RMC/RFH staff/employees. Please specify individual(s) to whom this restriction applies:

_____

_____

☐ Restrict disclosures to a family member, personal representative, other person involved in my care for purposes of location, general condition, or death.
(Facility Directory)

ACKNOWLEDGMENT OF CONDITIONS OF RESTRICTION (Patient to initial each condition)

1. _____ I understand that Regional Medical Center/Regional Family Health is not required to agree to this request for restriction.

2. _____ I understand that Regional Medical Center/Regional Family Health may agree to only a part of the request for restriction, while denying agreement to the remaining request.

3. _____ I understand that Regional Medical Center/Regional Family Health agrees to the requested Restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:
   a. I agree to or request in writing that the restriction be terminated.

   b. Regional Medical Center/Regional Family Health notifies me in writing that it is terminating the agreement to restrict. If Regional Medical Center/Regional Family Health terminates the agreement to restrict, then the termination is effective only with respect to information created or maintained after the date of restriction.

   c. Emergent life or death situation arises in which restricted personnel need to access protected health information to effectively treat me as a patient.

_____ _____
Patient Signature Date

Section B: To Be Completed by Privacy Officer

Date of Receipt of Request: _____

Request for restricted use and disclosure has been: Accepted Denied

Staff Comments:

_____

_____

_____

Signature of Privacy Officer: _____

Section C: To Be Completed by Information Services Staff

Following restrictions applied:

_____

_____

_____

_____

Signature of staff member: _____ Date: _____

Print name and title

_____

Section D: Request to Lift Restriction

Please lift the following restrictions:

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Signature of staff member lifting restriction Date

Completed document to be scanned into patient's electronic record.