University of Colorado Colorado Springs

Request to Restrict Uses or Disclosures of Personal Medical Records

I, _____(Patient Name), hereby request to restrict certain uses or disclosures of my medical records from _____(Name of Practice or Physician). Under federal law 104-191, also known as HIPAA, I am entitled to such restrictions of uses or disclosures upon written request.

I request the following restriction(s) on uses and disclosures of my personal medical records:

Policies and Limitations on Restrictions of Uses and/or Disclosures

- Under federal law, while you have the right to request restrictions on uses or disclosures of your personal medical records, we must accept and comply with your written request if:
  - Except as otherwise required by law, the disclosure is to a health plan for the purpose of carrying out payment of health care operations (and is not for purposes of carrying out treatment); and,
  - The personal medical information pertains solely to a health care item or service for which we have been paid out-of-pocket in full.
- Upon accepting your request, we must abide by it, except in emergency situations where a use or disclosure is necessary to provide treatment.
- Under federal law, restrictions on use or disclosure do not apply to the following types of uses and disclosures, for which no consent, authorization, nor opportunity to agree or object is required:
  - Public Health
  - Abuse
  - Neglect or Domestic Violence Reporting
  - Health Oversight
  - Judicial or Administrative Proceedings
  - Law Enforcement
  - Research under Privacy Board or IRB Waiver
  - Immediate Threats to Public Safety
  - Government Functions; or
  - Uses and Disclosures otherwise required by Law.
- We may terminate our agreement to restrictions if:
  - You agree to or request the termination in writing

- You request the termination verbally (we will document your verbal request to terminate restrictions)
- We inform you that we are terminating our agreement to restrictions (such termination is only effective for information created or received *after* we inform you of our termination)

Patient Name: _____

Address: _____

_____

_____

Telephone: _____

Email: _____

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:			
Date Received:		**Time Received:**	
Action(s) Taken:			
Records Flagged for Restriction(s):			
Patient Follow-Up:			
Staff Signature:			