



Request Restrictions On Uses and Disclosures of PHI

OSU Medicine is committed to providing high quality patient care. As such, OSU Medicine believes that complete and accurate information should be readily available to all staff in performance of their duties and that barriers to efficient quality care should be eliminated. Since restrictions placed on use and disclosure of your health information may interfere with the timely provision of patient care, OSU Medicine reserves the right to review and deny any restriction requests for reasons other than pre-payment.

However, OSU Medicine also recognizes that unique personal situations may cause you to request restrictions on uses and disclosures of your health information. OSU Medicine believes that you should be aware of some issues that may result from this request. Although OSU Medicine will strive to minimize the possibility of these issues arising, we are requesting that you read and acknowledge receipt of this information:

- Any restrictions we accept will not apply when your information is needed to provide you with emergency treatment.
- Any restriction we accept will be limited to information under our control. For example, this does not include information sent to you from your insurance company.
- Any restriction we accept will not apply to mandatory disclosures enumerated in 45 CFR 164.512.
- Even if a restriction is granted, it will not prevent the requesting individual from access to their own health information, nor will it prevent the individual from appearing in a directory of the facility, unless specifically requested.
- In some cases, we have the right to terminate agreed upon restrictions. If we do so, we will inform you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.
- Completion of this form will restrict the release of the designated information from the originating department only. It will not assure that communications from health care providers or staff in OSU Medicine departments, clinics or laboratories other than the originating department or clinic will be redirected. It is the responsibility of the patient to inform all clinical areas within OSU Medicine from which he/she is receiving treatment of this request. It is also the responsibility of the patient to inform all health care providers that are not within OSU Medicine of this request.
- Requests to not bill your insurer require that:
 - Payment be made in full prior to the service
 - You are not a Medicare or Medicaid beneficiary regarding a service covered by Medicare or Medicaid.
 - The service is not related to a Worker's Compensation claim.

Complete this form to acknowledge that issues associated with restrictions on use and disclosure of your health information has been read and that you request the restriction. You have the right to request us to terminate a restriction to the extent that such termination applies to information created or received after the date of termination.

Patient Name: _____ (PLEASE PRINT)	
Do not release information specified below to: _____	
Information: _____	
Date Effective: ____ / ____ / ____	Date Terminated: ____ / ____ / ____

I HEARBY REQUEST RESTRICTION (S) MARKED ABOVE TO BE TERMINATED:

SIGNATURE OF INDIVIDUAL OR

PERSONAL REPRESENTATIVE: _____ Date: ____ / ____ / ____

FOR OFFICE USE ONLY

- ☐ We have accepted the restriction(s) you have requested above. Any exceptions are listed below:
- ☐ We are unable to accept the following restrictions you have requested:

☐ By this form being sent to you, we are informing you that the above restrictions are being terminated

SIGNATURE OF LICENSED

HEALTHCARE PROFESSIONAL: _____ DATE: ____ / ____ / ____

Copies to: ☐ Patient Chart ☐ Patient