Patient Request for Restriction

Hillsborough County Patient Request for Restriction of Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

Right to Request Restrictions Regarding Your PHI and Our Duties:

Hillsborough County is committed to protecting your personal health information under the HIPAA Privacy and Security Rules 45 C.F.R. §§ 164.103, 164.105.

You (or your authorized representative) have the right to request that we restrict how we use or disclose your PHI for treatment, payment or healthcare operations, or to restrict the information that is provided to family, friends and other individuals involved in your healthcare. However, we are only required to agree to a requested restriction when you ask that we not release PHI to your health plan (insurer) about a service for which you have paid Hillsborough County in full. We are permitted, but not required, to agree to other requested restrictions. But, we are required to abide by any restrictions that we have agreed to honor.

Request for Restriction of PHI:

Below, please explain your request for restricted uses and disclosures of your PHI. Please indicate for what purposes you would like to restrict the PHI and specific parties to whom you would like us to not provide PHI. Hillsborough County will consider your request and promptly let you know whether or not we agree to your requested restriction(s).

_____

_____

_____

Signature of Requestor: _____ ***Request Date:*** _____

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____