

Patient label if available or

Print patient name

and account number

Patient Request to Restrict Use/Disclosure of Health Information

(to be completed with assistance of clinic/facility manager or other designee)

CLINIC/FACILITY NAME: _____

I want to request the following restriction on the use or disclosure of my health information:

- Describe the information you want restricted:

- Check whether you want the information restricted from use by UAMS or disclosure outside of UAMS, or both by checking one or both of the boxes that apply to your request:

Do not use this information within UAMS

Do not disclose this information outside UAMS

- Specify the persons or entities you want this restriction applied to:

THIS REQUEST WILL APPLY ONLY TO THIS CLINIC/FACILITY.

IF YOU WISH FOR RESTRICTIONS TO APPLY TO ANY OTHER UAMS CLINIC OR FACILITY, PLEASE CONTACT THAT CLINIC/FACILITY AND COMPLETE A RESTRICTION REQUEST FORM.

THIS REQUEST IS SUBJECT TO REVIEW AND MAY NOT BE APPROVED.

Signature of Patient or Legal Representative

Date

If Legal Representative, authority of Legal Representative _____

(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

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Staff Use Only

UAMS response to request: agreed to request denied request

Informed Patient: verbally in writing Date: _____

Comments: _____

Signature of UAMS Authorized Personnel

Date

File Original in Patient's medical record and send a copy to the UAMS HIPAA Office, #829