(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

Patient Request to Restrict Use/Disclosure of Health Information

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

CLINIC/FACILITY NAME: _____

Patient Name: _____ Medical Record No. (if known): _____

Date of Birth: _____ Phone: _____

Address: _____ _____ _____ _____
Street Address City State Zip

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 disclose this information to individuals or organizations outside UAMS

  ☐ Do not use this information within UAMS (This would include your UAMS Physicians & other staff)

- Specify the person(s) or entity(s) you want this restriction applied to:

  _____

  _____

THIS REQUEST WILL APPLY <u>ONLY</u> TO THIS CLINIC/FACILITY OR TO THIS INPATIENT OR EMERGENCY ROOM VISIT. IF YOU WISH FOR RESTRICTIONS TO APPLY TO ANY OTHER UAMS CLINIC OR FACILITY OR TO ANY OTHER INPATIENT OR EMERGENCY ROOM VISIT, 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 Time

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)

* * * * * * * * * * * * * * * **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 Time

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

UAMS Administrative Guide Policy 3.1.34