REQUEST FOR RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the attached form to Request for the Restriction of the Uses and Disclosures of Protected Health Information.

The HIPAA Privacy Rule provides an individual the right to request restrictions of uses or disclosures of protected health information about the individual to carry out treatment.

- St. Luke's Joint Notice of Privacy Practices discusses the right to request restriction.
- The request will be reviewed by St. Luke's and a decision made as to whether the restriction is granted.
- St. Luke's is not required to grant the restriction, except for requests to restrict disclosures to health plans. To request a restriction to disclose to your health plan(s), please do the following prior to or at the time of service(s):

    1. Complete section 7 of this form; and
    2. Submit payment in full.

    Requests for restriction may be mailed, faxed, or emailed to:

    St. Luke's Health System
    Attn: Privacy Officer- Compliance Office
    190 East Bannock Street
    Boise, Idaho 83712
    Phone: (208) 493-0383
    Fax: (208) 493-0572
    Email: privacyofficer@slhs.org

For more information about request for restrictions of the uses or disclosures of protected health information, you may contact the Privacy Officer at (208) 493-0383. Note, however, that requests for restriction must be made in writing and verbal requests will not be accepted.

PATIENT LABEL

REQUEST FOR RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ Date of Birth: _____
(Patient Name)

Address: _____

Phone Number: _____understand that:

1. There are legal restrictions on the manner in which St. Luke's may use or disclose health information about me.
2. I have the right to request additional restrictions on the way in which St. Luke's uses or discloses my health information, in addition to the restrictions already imposed by law.
3. St. Luke's is not required to grant my request for additional restrictions, with the exception of services I receive for which I do not want my insurance billed. St. Luke's will grant this restriction if the services provided are paid for in full prior to or at time of service. (Complete section 7 of the form)(HIPAA Self Pay Restriction).
4. If St. Luke's does grant my request for restrictions; the restricted information will not be used or disclosed except to provide treatment to me in an emergency, or in the case of HIPAA Self Pay restrictions; St. Luke's will not disclose the restricted information to my insurance company.
5. St. Luke's and I can terminate our agreement to a restriction at any time by notifying the other party. If St. Luke's terminates its agreement to a restriction, it will notify me, and will continue to comply with the restriction for any information that was created prior to the date of termination.
6. I request the following restrictions with respect to my Protected Health Information:

   _____

   _____

7. **HIPAA Self Pay**: I request that my insurance not be billed for the following services. (List all services for which this restriction is requested and the date of service.)

   _____

   _____

❑ **I have been given the HIPAA Elect Self-Pay Letter of Understanding.**

_____ _____
Signature of Patient (or personal representative) *Date/Time*

Request Approved / Request Denied (must be circled to be in effect)

_____ _____
Name & Signature of Privacy Officer or designee *Date/Time*

If you are the Patient's Personal Representative (e.g. guardian, agent, or parent of a minor) and can legally act for the patient, please fill out this section. Your status as a personal representative will be verified.

Name: _____ Relationship to patient: _____

Address if different from above: _____

Phone if different from above: _____

Signature: _____ Date: _____

PATIENT LABEL