KEYSTONE HEALTH

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF PHI

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your protected health information. This means you may ask us not to use or disclose any part of your PHI for purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request.

We must agree not to disclose your PHI to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

We reserve the right to terminate your requested restriction if:
• You agree to termination of the restriction, either in writing or verbally; or
• You requested the termination yourself.

Patient Name: _____

Street or PO Box: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

1) Protected Health Information to be restricted: _____

_____

_____

2) Nature of Restriction: _____

_____

_____

_____ _____

Signature of Patient/Personal Representative Date

_____

Personal Representative /Relationship to Patient

Please return the completed form either by fax or by mail to:

Keystone Professional Center
Attn: HIM Department
111 Chamber Hill Drive, Suite 200,
Chambersburg, PA 17201,
Phone (717) 709-7960 Fax: (717) 217-1937
Email: khc-him@keystonehealth.org

**********OFFICE USE ONLY**********

KHC RESPONSE:

_____ Your request for restriction has been **accepted.** In the case of an emergency or if necessary to comply with the law, we may use and disclose your health information in violation of the restriction. Other than in those circumstances, we will abide by your request unless and until the restriction is terminated (with or without your agreement) and you are notified.

_____ Your request for restriction has been **declined,** for the following reason (s):

_____

_____

_____

_____ _____

Signature of HIM Manager/Privacy Official Date

TERMINATION OF RESTRICTION

_____The above name patient agreed to terminate this restriction on: _____/_____/_____.

_____The above named patient was notified on _____/_____/_____ that this restriction was terminated. Purpose:_____

_____.

□ Patient was notified: (check appropriate box)

_____In person

_____By telephone (attach documentation of notification)

_____By mail (attach documentation of notification)

_____ _____

Signature of HIM Manager/Privacy Official Date