Request for Restriction on Use & Disclosure of Protected Health Information

Patient Information

Last Name	*First*	*Middle*		*Request Made on: (mm/dd/yyyy)*
Street Address	*City*	*State*	*Zip*	*Birth Date: (mm/dd/yyyy)*
Patient's Personal Representative Name				*Patient's Phone #*

Requested Restriction on Use and/or Disclosure

I hereby request that Lamoille Health Partners restrict the Use & Disclosure of my health information in the following manner: **Please specify the type of health information and the requested restriction:**

Acknowledgement of Conditions of Restriction

I understand that Lamoille Health Partners does not have to agree to my requested restriction(s) unless this request is to restrict disclosures made for payment or health operations and you have **PAID IN FULL** for services rendered.

If Lamoille Health Partners agrees to the requested restriction, then the restriction is in effect until one of the following events occurs:

☐ I agree to or request in writing that the restriction be terminated; or

☐ Lamoille Health Partners notifies me in writing that they are terminating restrictions, in which case the termination is effective for all PHI created or received on or after the date of the letter.

Date: _____

Signature of Patient/Representative: _____

Printed Patient/Representative Name: _____

For Lamoille Health Partners Internal Use Only

Date request received: *(mm/dd/yyyy)*	☐ Restriction Accepted ☐ Services Paid in Full	☐ Restriction Denied

If denied, list reason(s) for denial:

☐ Individual was informed of decision in writing on: ____/____/_____

☐ Individual terminated this agreement on: ____/____/_____

☐ Lamoille Health Partners terminated this agreement. Written notice sent on: ____/____/_____

Signature of Lamoille Health Partners Privacy & Security Officer: _____ Date: ____/_____/_____