Request for Restrictions on the Use or Disclosure of Protected Health Information

Human Services

PO Box 67 Jackson, MN 56143 (507) 847-4000 or PO Box 9, Windom, MN 56101 (507) 831-1891

Public Health

402 White St, Ste 201 Jackson, MN 56143 (507) 847-2366 • (800) 622-5207 or 235 9th Avenue Windom, MN 56101 (507) 831-1987 • (800) 247-1401

Patient Information			Request Date:
Patient Name:		Patient Date of Birth:	
Patient Address		City, State, Zip	

I am requesting that Des Moines Valley Health and Human Services not use or disclose my protected health information in the manner that I describe below. I understand that Des Moines Valley Health and Human Services will review this request and may deny this request for any reason. If my request is approved, I understand that the restriction will not apply in case of an emergency situation. **Initial** _____

I understand that if I am requesting a restriction for the use and disclosure of protected health information to my insurance company, I must pay in full, out of pocket prior to the services be rendered. **Initial** _____

Person and/or Organization Restricted from Use and/Or Disclosure of PHI (Name, Address, Phone Number):

_____

Description of specific Health Information to be Restriction (must be specific): _____

_____

I understand that the provider may or may not be able to approve and/or accommodate my request for restriction. I understand that this request is only valid for the dates of service listed above for the services provided.

If the above is my health plan, I agree to pay Des Moines Valley Health and Human Services in full for the services rendered during this visit. I understand that if I wish to restrict future information from my health plan, I must request a restriction during subsequent visits.

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

Name of Legal Representative, If Applicable: _____

Reason Patient Can't Sign, If Applicable: _____

FOR PRACTICE'S INTERNAL USE ONLY

Date Received:	Date Processed:	□ Accepted	□ Denied

If denied, document reason for denial:

❑

Date Letter Sent to Patient:

_____ _____

Signature/Title of Staff Member **Date**