# Request for Restriction of Use or Disclosure of Protected Health Information (PHI)

Yale Health (YH) is committed to providing high quality patient care. As such, we believe that complete and accurate information should be readily available to all staff and that barriers to efficient, quality care should be eliminated.

While restrictions on the use and disclosure of your information for treatment, payment or operations may interfere with the timely provision of patient care, you have a right to request such restrictions. You also have a right to request a restriction of permitted uses and disclosures to those involved in your care (*e.g.*, family member, friend, etc.).

**While you may request a restriction, we are only required to agree to restrictions under very limited circumstances.**

**By completing this form, I understand that:**

- Any restrictions we accept will not apply when your information is needed to provide you with emergency treatment or in certain other limited circumstances.
- Any restriction accepted will be limited to information under our control. For example, this does not include information sent to you from your insurance company. If you have concerns regarding restricting information created by another entity, you must contact that organization to place a request.
- We cannot restrict the sharing of or access to your medical information within the electronic medical record to individual medical staff members, employees, Business Associates, or those who utilize or license an instance of our electronic medical record system for treatment, payment, or operations related purposes. If you have concerns about access to your electronic medical record, please contact the respective Privacy Office noted at the end of this form.
- We have the right to terminate any agreed upon restriction by informing you of the termination in writing; the termination will only apply to information created or received after we have informed you of the termination.
- If you no longer wish for a restriction to be in place, you have the right to request in writing that the restriction be discontinued.

**PATIENT INFORMATION:**

Patient Name: _____ DOB: _____

Patient Address: _____

Phone Number: _____ Email Address: _____

**PLEASE SPECIFY REQUEST:**

☐ **I request to restrict use and disclosure of my information for the treatment, payment or operations related purposes described below:**

_____

☐ **I request to restrict use and disclosure of my information to the following person or entity (provide name of person & relationship, or entity name):**

_____

☐ **I am requesting that a prior, agreed upon restriction, be discontinued.**
Specify prior restriction request and approximate timeframe requested:

_____

**I understand that completion of this form does not mean this request has been accepted. This request will be reviewed by the respective Privacy Office noted below and I will be informed if this request is accepted.**

**SIGNATURE:**

_____ _____

**Signature of Patient or Authorized Representative**** **Date**

*If not patient, please indicate relationship:* _____

***Must provide proof of legal authority (except parent of a minor)*

Submit request to:

Email: HIPAA@yale.edu
Or Mail: Attn: HIPPA Office, P.O. Box 208255, New Haven, CT 06520
Phone: 203-432-5919

Yale HEALTH

**FOR PRIVACY OFFICE USE ONLY:**

- ☐ Request has been granted with the following exception(s), if applicable:
  Action Taken:
  _____

- ☐ Request is denied for the following reason(s): _____

Approved by Name/Title: _____ Date: _____