

YNHH MRN#: _____ IDX Account Number: X _____

Request Restrictions On Uses and Disclosures of PHI

The Yale School of Medicine is committed to providing the highest quality patient care. As such, YSM believes that complete and accurate information should be readily available to all staff in performance of their duties and that barriers to efficient quality care should be eliminated. Since restrictions placed on use and disclosure of your health information may interfere with the timely provision of patient care, YSM strongly discourages this practice.

However, YSM also recognizes that unique personal situations may cause you to request restrictions on uses and disclosures of your health information. YSM believes that you should be aware of some issues that may result from this request. Although YSM will strive to minimize the possibility of these issues arising, we are requesting that you read and acknowledge receipt of this information:

- Any restrictions we accept will not apply when your information is needed to provide you with emergency treatment.
- Any restriction we accept will be limited to information under our control. For example, this does not include information sent to you from your insurance company.
- We have the right to terminate any agreed upon restriction by informing you of the termination in writing. Such termination will only apply to information created or received after we have informed you of the termination.
- Completion of this form will request restriction of the release of the designated information from the originating department only. It will not assure that communications from health care providers or staff in YSM departments, clinics or laboratories other than the originating department or clinic will be redirected. It is the responsibility of the patient to inform all clinical areas within YSM from which he/she is receiving treatment of this request. It is also the responsibility of the patient to inform all health care providers who are not within YSM of this request.

Complete this form to acknowledge that issues associated with restrictions on use and disclosure of your health information have been read and that you request the restriction. You have the right to request us to terminate a restriction to the extent that such termination applies to information created or received after the date of termination.

Name of Patient: <i>(Please Print)</i> _____	
Do not release information specified below to: _____	
Information _____	

Effective Date _____	Date Terminated _____

I hereby request restriction(s) marked above to be terminated.

_____	OR	_____
Signature of Patient	Date	Parent/Legal Guardian/Authorized Person
		Date

		Relationship to Patient

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Patient Name:	
YNHH MRN #:	IDX Account #: X

For Office Use Only:

<input type="checkbox"/> We have accepted the restriction(s) you have requested above. Any exceptions are listed below:
<input type="checkbox"/> We are unable to accept the following restrictions you have requested: <hr/> <hr/>
<input type="checkbox"/> By this form being sent to you, we are informing you that the above restrictions are being terminated.
Signature of Licensed Healthcare Professional: _____ Date: _____

Original to:

Patient Chart

Copies to:

Patient

YSM Deputy Privacy Officer

Form #: YSM HIP09

Original Date of Form: Effective Date: April 14, 2003

Revised Date: April 8, 2003