

**Yale University Form
Request Restrictions On Uses and Disclosures of PHI**

Yale University is committed to providing high quality patient care. As such, Yale 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, Yale also recognizes that unique personal situations may cause you to request restrictions on uses and disclosures of your health information. Yale believes that you should be aware of some issues that may result from this request. Although Yale 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.
- In some cases, we have the right to terminate agreed upon restrictions. If we do so, we will inform you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.
- Completion of this form will restrict the release of the designated information from the originating department only. It will not assure that communications from health care providers or staff in Yale 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 Yale from which he/she is receiving treatment of this request. It is also the responsibility of the patient to inform all health care providers that are not within Yale of this request.
- Requests to not bill your insurer require that:
 - Payment be made in full prior to the service
 - You are not a Medicare or Medicaid beneficiary regarding a service covered by Medicare or Medicaid.
 - The service is not related to a Worker's Compensation claim.

Complete this form to acknowledge that issues associated with restrictions on use and disclosure of your health information has 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.

| | |
|--|------------------------------|
| Patient Name: _____ (PLEASE PRINT) | |
| Do not release information specified below to: _____ | |
| Information: _____ | |
| Date Effective: ___/___/___ | Date Terminated: ___/___/___ |

 I HEARBY REQUEST RESTRICTION (S) MARKED ABOVE TO BE TERMINATED:
 SIGNATURE OF INDIVIDUAL OR
 PERSONAL REPRESENTATIVE: _____ Date: ___/___/___

| | |
|---|-----------------------|
| 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: _____ | |
| <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: ___ / ___ / ___ |

Copies to: Patient Chart Patient