Salem Health

Request for Restriction on Use and Disclosure of Protected Health Information (PHI)

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____

Street: _____ **City:** _____ **State/Zip:** _____

I request that Salem Health restrict the use of my PHI as specified below. I understand Salem Health is under no obligation to agree to my request, and that there will be no agreement unless Salem Health informs me in writing that it agrees to my request. Even if Salem Health agrees to my request, Salem Health may continue to disclose the restricted information as outlined in the Notice of Privacy Practices in the following situation:

- In a medical emergency when information is needed for my treatment;
- When I authorize Salem Health in writing to use or disclosure the information, or;
- When law requires the use or disclosure.

RESTRICTIONS REQUESTED

____ Appointment Reminders

____ Health-related Products and Services

____ Media

____ Soliciting Funds for the Organization

____ Treatment Alternatives

____ Disclose to Health Plan/Insurance

You have the right to request Salem Health not disclose information about your treatment to your health plan for purposes of payment. If you do not want Salem Health to disclose your health information to your health plan for a specific item/visit, Salem Health must be notified prior to the time of service and the amount for the health care item/ service ***must be paid in full****.*

Description of the Health Care Item/Service: _____

_____

_____

Health Plan/Insurance: _____ Amount Paid: _____

Date of Service: _____ Date Paid: _____

I CONSENT TO THE ABOVE REQUEST FOR RESTRICTIONS

_____ _____

Signature *(If signed by a personal representative, please give Name & Relationship)* ***Date***

Personal Representative's Name: _____

Relationship to Patient: _____

Salem Health will respond to your request within 30 days, unless your request includes protected health information that is not maintained on site or readily accessible to Salem Health. In these circumstances, you will be notified that your request may take up to 60 days.

Mail this form to: Salem Health Privacy Officer
P.O. Box 14001
Salem, OR 97309-5014