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

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

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

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

RESTRICTION ON MEDICAL INFORMATION USED/DISCLOSED FOR TREATMENT, PAYMENT & OPERATIONS

I would like Salem Health Hospitals and Clinics to restrict the use or disclosure of my medical information in the following manner:

_____

_____

_____

Additional restrictions available:

	Appointment reminders		Soliciting funds for the organization
	Health-related products and services		Treatment alternatives
	Media		

LIMITATION ON MEDICAL INFORMATION DISCLOSED TO FAMILY MEMBER/FRIEND WHO IS INVOVLED IN CARE OR PAYMENT FOR CARE

I would like Salem Health Hospitals and Clinics to restrict the use or disclosure of my medical information to the following family member/friend who is involved in care or payment for care in the following manner:

_____ _____

Family member/friend involved in care or payment Relationship to Patient

Medical Information to be Restricted:

_____

_____

_____

RESTRICTION ON USE AND DISCLOSURE OF PHI TO A HEALTH PLAN/INSURANCE

- I have the right to request a restriction of disclosure of PHI to my health plan for which I have paid in full before the time of service.
- Salem Health is required to agree to the restriction; and the requested restriction only applies to release of information to a Health Plan for purposes of payment or health care operation.
- This request only covers Salem Health Hospitals and Clinics facility and Salem Health Medical Group professional portion of the service.

- It is my responsibility to notify other providers including physicians, laboratories, anesthesiology, and/or imaging of my request for restriction on the care they provide related to this service.
- This restriction request covers this, and only this health information provided on this date of service.
- I understand that this restriction is in effect until I request, or agree, in writing that the restriction can be terminated.

I have paid out of pocket in full for the following item/service and I hereby request that Salem Health Hospitals and Clinics restrict the following use and disclosure of health information:

Description of health care item/service	Service Date	Health Plan/Insurance

I CONSENT TO THE ABOVE REQUEST FOR RESTRICTIONS

I request that Salem Health restrict the use of my PHI as specified above. I understand Salem Health is under no obligation to agree to my request, unless if it is a restriction on use and disclosure of my PHI to a health plan/insurance, 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(s):

- 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.

Patient Signature (if signed by a personal representative, please provide name and relationship below) Date

Personal Representative's Name and Relationship to Patient

Salem Health Hospitals and Clinics will respond to your request within 30 days.

Please send completed form to: Salem Health Privacy Officer
P.O. Box 14001
Salem, OR 97309