HEALTH
UNIVERSITY OF UTAH

**PATIENT REQUEST FOR PRIVACY RESTRICTION FOR**
**"HEALTH CARE SERVICES PAID FOR OUT-OF-POCKET"**

**Patient Name** _____ **Medical Record #** _____

**Date of Birth** _____ **Phone # (_____)**_____

**Patient Address**_____ **City:** _____ **State:** ____ **Zip:** _____

I understand that I have the right to request that University Health Care not disclose protected health information to my health plan. University Health Care is not required to agree to the restriction I request unless it is about a health care service that I have paid for in full and out-of-pocket. In general, payment in full is expected within one billing cycle. However, University Health Care may require partial or full payment prior to services being rendered.

*I understand that if I receive a health care service that I have not paid for in full and out-of-pocket, as agreed, this request for restriction will no longer be valid*. At that time, University Health Care may submit the claim to my health insurance or initiate other collection activities.

I understand that this restriction applies only to this visit. I understand that if I want the same information restricted from my health insurance at future visits, I must make a new request.

_____ _____
Signature of Patient or Representative Date

_____
If Applicable, Print Name of Personal Representative*

*Description of Personal Representative Authority:

☐ Parent ☐ Medical Power of Attorney

☐ Other, explain: _____
and attach documentation.

***Signature must be verified by U of U Health staff or notarization may be required. When complete, place in patient's medical record.***

- _____ _____ _____
  Signature of UHC Employee Printed Name and Employee ID# Date

- SUBSCRIBED AND SWORN before me this ____ day of _____, 20____.

NOTARY PUBLIC

Residing in _____

My Commission expires: _____

*RELEASE OF INFORMATION*