PATIENT REQUEST FOR SPECIAL PRIVACY RESTRICTION

Patient Name ____ **Medical Record #** ________________________________

Date of Birth ____ **Phone # (_______)**_______________________________

Patient Address_________________________________ **City:** ________________________ **State:** ____ **Zip:** _________

Soc. Sec.# ____ **(Providing your SS# is voluntary, but necessary to accurately identify your medical records, if you fail to provide Medical Record Number**

Approximate Dates of Treatment: ____

I request that the University of Utah Health Care ("UHC") restrict the use or disclosure of my protected health information for treatment, payment, or health care operations in the manner described here (please be specific):

____

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I understand that the UHC is not required by law to accept my requested restrictions, but if accepted, the UHC agrees to abide by the restrictions except in emergency situations. **I understand that if this request is accepted and put into place, it may impact my care and/or safety negatively.** I also understand that either I or the UHC may terminate this restriction in writing at any time in the future.

__________________________________ ____________
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

University of Utah Health Care Internal Use

☐ Date Received: ___________________________

☐ A 30 day extension as been requested. Reason: ____

☐ Patient Notified of Extension On: ____

☐ **Request Approved:**

☐ Date Implemented: ___________________________

☐ **Request denied. Check reason for denial:**

☐ Implementation of request not achievable

☐ Other: ____

☐ Request Processed by (Name and Employee ID): ____

☐ Sent written notification by certified mail.

☐ **Patient notified of approval or denial: ______________________ (date)**

When complete, place in patient's medical record. If you have questions, contact the HIPAA Privacy Office at 7-9241.