HARRISHEALTH SYSTEM

Request for Restriction on Use and Disclosure of Protected Health Information

I hereby request the following restrictions for use and disclosure of protected health information (PHI) contained in medical records or billing records maintained by Harris Health System (Harris Health).

Restriction Request:

If Harris Health accepts your request, we will comply with your request unless the information is needed to provide you with emergency treatment. If we can no longer comply with the request, we will notify you in writing of the termination of the agreed to restriction. If you would like to pay in full for health care items or services and to restrict disclosure of PHI for such items or services to your health plan, please ask Harris Health Registration staff for further guidance (see Form 283576).

Signature _____ Date _____

Printed Name _____

Relationship if not Patient _____

Patient or Personal Representative's Address _____

FOR HARRIS HEALTH SYSTEM USE ONLY:

Immediately fax this form to Harris Health's Privacy Officer at 713-566-6543 for approval or denial.

The above request has been **accepted/denied** (circle one).

Your request for restrictions has been denied for the following reason/s:

_____ _____

[Signature of Privacy Officer or Designee] [Date]