ISLAND HOSPITAL

This form is used for an individual's request to restrict use or disclosure of protected health information. Please print and complete all required fields.

Individual requesting restriction

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient ID Number: _____ Date of Birth: _____

You have the right to request Island Hospital restrict the use or disclosure of your protected health information. Island Hospital will attempt to honor your request although we are not legally obligated to do so with the exception of a provider who previously provided health care to you. If we agree to your request, we will notify you in writing.

Even if we agree to your request, we may continue to use or disclose the restricted information in the following situations:

- In a medical emergency when the information is needed for your treatment;
- When you authorize us in writing to use or disclose the information, or;
- When law requires the use or disclosure.

You may end the restriction at any time by notifying us in writing. We may end the agreement at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we receive after we gave you our notice terminating the restriction.

Please list the protected health information you would like to restrict:

_____

_____

Please state the restriction you would like to apply and the reason for the request:

_____

_____

I request that Island Hospital restrict the use or disclosure of my protected health information as specified in above. I understand that Island Hospital is under no obligation to agree to my request, and that there will be no agreement unless Island Hospital informs me in writing that it agrees to my request.

SIGNATURE: _____ DATE: _____

(If signature by a personal representative, please complete the following)

Personal representative's name: _____
Relationship to member: ____Parent ____Legal guardian* ____Holder of Power of Attorney*

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

Restriction Request Processing—To be completed by Privacy Official or other authorized individual

Date restriction request received: ____/____/____

Date transmitted to Privacy Official: ____/____/____

Action to determine whether to reject or accept restriction request:_____

_____

_____

_____

Response to Restriction Request—To be completed by Privacy Official or other authorized individual.

Request denied on ____/____/____ by transmittal of Denial of Restriction Request to the individual.

Request granted on ____/____/____ by transmittal of Agreement to Restriction Request to the individual.

Company units and business associates notified of the accepted restriction:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

ISLAND HOSPITAL

DENIAL OF RESTRICTION REQUEST

{DATE}

{INDIVIDUAL'S NAME}
{INDIVIDUAL'S ADDRESS}

Dear {INDIVIDUAL}:

We decline your ____/____/____ request that we restrict our use or disclosure of your protected health information. That means we will be permitted to use or disclose the protected health information that we create, receive or maintain about you in accordance with our Notice of Privacy Practices that we have given to you.

[OPTIONAL: We have declined your request for the following reason: _____]

If you have questions or want to discuss the denial of your restriction request, please contact {CONTACT PERSON OR OFFICE} at {CONTACT INFORMATION}.

Sincerely,

Island Hospital

By:

_____
_Privacy Official

ISLAND HOSPITAL

AGREEMENT TO RESTRICTION REQUEST

{DATE}

{INDIVIDUAL'S NAME}
{INDIVIDUAL'S ADDRESS}

Dear {INDIVIDUAL}:

We agree to restrict our use or disclosure of your protected health information in accordance with your request on ____/____/____. We will not use or disclose the protected health information you identified in your request contrary to the restriction you requested as long as this agreement remains in effect, *except* we may use or disclose the restricted information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information or when the use or disclosure is required by law.

You may end this restriction agreement at any time by notifying us in writing. We may end this restriction agreement at any time by notifying you in writing. If you agree with our decision to end this restriction agreement, your protected health information will no longer be subject to the restriction. If you disagree, our termination of this restriction agreement will apply only to your protected health information that we receive after we gave you our notice terminating this restriction agreement.

If you have questions or wish further information, please contact the Privacy Officer at {CONTACT INFORMATION}.

Sincerely,
Island Hospital

By:

_____
_Privacy Official

[For use by Island Hospital for internal or business associate communication]

ISLAND HOSPITAL

NOTIFICATION OF RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To _____

_____

_____

From: Island Hospital
{INSERT PRIVACY OFFICIAL NAME AND CONTACT INFORMATION}

On ____/____/_____, our Company agreed to a request from the individual below to restrict our use or disclosure of the following protected health information:

_____

_____

The restriction that applies to the above protected health information is:

_____

_____

You must ensure that the above protected health information is neither used nor disclosed in violation of the above restriction. Should the restriction be modified or removed, we will notify you in writing. If you have questions, please contact me.

Sincerely,

_____ Date: _____

Privacy Officer

Individual Requesting Restriction:

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient ID Number: _____ Date of Birth: _____