Keck Medicine of USC

REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF PROTECTED HEALTH INFOMRATION (PHI)

Patient's Name: _____
Last First Middle Date of birth

Home Address: _____

I hereby request that this Keck Medicine of USC ("Keck Medicine") site apply the following restriction on uses and disclosures of my health information (PHI). **Please DO NOT disclose my PHI to:**

☐ Family ☐ Friend(s) ☐ Insurance Company ☐ Physician(s) ☐ Other: _____

Explain exactly who the restriction applies to: _____

Information to be restricted: ☐ Contact information ☐ Photographs ☐ Diagnosis ☐ Treatment notes/orders

Reason for Request: _____

Request for Restriction to apply to the following Keck Medicine site:

NOTICE: THIS REQUEST FOR RESTRICTION WILL ONLY BE EFFECTIVE UPON APPROVAL AT THE SITE(S) WHERE YOU SUBMIT THIS REQUEST. YOU MUST SUBMIT A SEPARATE REQUEST FOR RESTRICTION AT EACH KECK MEDICINE SITE WHERE YOU RECEIVE SERVICES.

Information on your right to request a restriction. You have the right to ask Keck Medicine to restrict how Keck Medicine uses and discloses your protected health information for purposes of treatment, payment, or health care operations. You also have the right to ask Keck Medicine to restrict disclosures made to those family members or other involved in your care or involved in payment for your care or for notification purposes. Keck Medicine is not required to agree to your request. If Keck Medicine agrees with your request, we will put it in writing and will abide by the agreement except when you require emergency treatment. If Keck Medicine does not agree with your request, we will notify you of our decision in writing.

Termination of Restriction. You have the right to withdraw a restriction you originally requested and must notify Keck medicine of the withdrawal in writing. Keck Medicine may also terminate a restriction it originally agreed to, but which it can no longer accommodate, and will notify you in writing.

Acknowledgment. By submitting this form, I hereby request Keck Medicine to restrict the uses and disclosures of my health information as described above. I understand and acknowledge that Keck Medicine is not required to agree to my request.

PATIENT OR PERSONAL REPRESENATIVE PRINTED NAME:_____

SIGNATURE:_____ DATE:_____

If Personal Representative has signed above, please indicate your relationship to the patient:

☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other