Jefferson

* 9 2 0 2 3 8 *

REQUEST FOR RESTRICTIONS OF PROTECTED HEALTH INFORMATION FORM

Patient Name: _____

Date of Birth: _____

Last 4 digits of Social Security Number: _____

Address: _____

_____

_____

Phone Number: _____

Medical Record Number: _____

Addressograph or Label - Patient Name, Medical Record Number

Except for uses and disclosures as required by law, you have the right to ask Jefferson Health to restrict the use and disclosure of your protected health information (PHI) for Treatment, Payment or Health Care Operations as is identified below:

☐ **Restriction of record release to a Health Information Exchange (HIE):**
Jefferson Health participates in Health Information Exchanges (HIEs) which, through secure connected networks with health care providers who participate in the HIEs, makes it possible for us to electronically share protected health information to coordinate patient care. We may electronically share your medical information through HIEs, among participating HIE members for the purposes of treatment, payment, health care operations, and other authorized purposes, to the extent permitted by law.

☐ **Restriction on Use and Disclosure of PHI in the In-Patient Hospital Directory**
You have to right to restrict the use and disclosure of health information to notify those persons of your location, general condition, or death - or to coordinate those efforts with entities assisting in disaster relief efforts.

☐ **Restriction of record release for a Self-Pay Encounter to your Health Insurance provider**
You have the right to restrict the release of your medical record to your health insurance provider **ONLY IF** the cost of the service or procedure is paid in FULL at the time of registration. This restriction does not apply to ancillary services such as your provider, pharmacy or outside labs, etc.

☐ Other: (Please Specify):_____

_____

Jefferson is not required to agree to your request and is not permitted to grant restrictions that violate the law. If Jefferson agrees to your request, then we will be bound by the restriction unless the restriction is later ended by (i) your written request; (ii) by agreement between you and Jefferson (including an oral agreement); or (iii) by Jefferson for health information created or received after you are notified that Jefferson has removed the restrictions. Jefferson may also release the restricted information if you require emergency treatment, or to comply with the law.

If you checked the box labeled "Other", Jefferson will review your request and provide you with a written response. Depending upon the nature your request, it may take several days to respond. Until your request has been accepted Jefferson will use and disclose your health information in a manner consistent with our Notice of Privacy Practices and applicable law.

Patient Signature:_____ Date_____

If other than the patient, specify relationship _____

If document is interpreted

_____	_____	_____
Interpreter Signature	***Print Name***	***Language***
_____	_____	_____
Date	***Position***	***Relationship to Patient***

After you have completed this form, please return it by mail to

Health Information Management Department
Thomas Jefferson University Hospital,
111 S. 11th Street, Suite 1950 Gibbon,
Philadelphia, PA 19107