Forest County Potawatomi Health and Wellness Center Patient Request for Restriction of Use and Disclosure of Protected Health Information

I understand that I have the right to request restrictions regarding the use and disclosure of my protected health information for purposes of treatment, payment or health care operations or for involvement in my care or payment related to the care or for notification purposes. I understand that the Forest County Potawatomi Health and Wellness Center (FCPHWC) is not required to agree to this request.

Patient Name: _____

Medical Record #: _____
[Office Use Only]

Section I - To be completed by patient

A. Briefly describe the restriction(s) you are requesting:

_____
_____
_____
_____
_____

B. Signature of Patient or Legal Representative: _____ _____
Date: _____

[If Legal Representative, state relationship to the patient]: _____

_____

Section II - Office Use Only

A. Check one:

_____ FCPHWC agrees to the requested restriction.
_____ FCPHWC does not agree to the requested restriction.

Notes, if any:

_____
_____

B. Signature: _____ **Date:** _____

- Direct Service Provider
- Compliance Coordinator / Privacy Officer

Printed Name: _____

Section III - Office Use Only

A. Termination of Restriction Agreement

FCPHWC is terminating its agreement to restrict its use and disclosure of the patient's protected health information (please check the applicable box):

- The patient has agreed to or requested the termination in writing.
- The patient orally agreed to the termination and FCPHWC has documented the patient's agreement.
- The patient has been sent written notification that FCPHWC is terminating its agreement to the restriction.

B. Signature: _____ **Date** _____
Direct Service Provider

Printed Name: _____

C. Signature: _____ **Date** _____
Compliance Coordinator / Privacy Officer

Printed Name: _____