PROVIDENCE
Health & Services

SWEDISH

PATIENT REQUEST TO RESTRICT A DESIGNATED RECORD SET

The purpose of this form is to allow a patient to request that Providence Health & Services (PH&S) restrict how their information is used, or to whom it is disclosed. This form is used to make a request, however it does not guarantee that PH&S can or will accept the requested restriction. PH&S will review all patient requests and will reply back in writing.

This form must be completely and legibly filled out and returned for processing to:

A letter of acceptance or denial will be provided within ten (10) business days.

Restrictions may be terminated if:

- You request, or agree to, the termination in writing
- You orally agree to the termination and oral agreement is documented
- PH&S informs you that it is terminating its agreement. In this case, the termination is only effective for protected health information created or received AFTER you have been notified of the termination.

All requests, revocations, approval, denial, or appeals will become a part of your permanent medical record.

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PATIENT REQUEST TO RESTRICT A DESIGNATED RECORD SET

Patient's Name: ______ DOB: ______

Other Name(s) Used: ______

Address: ______ Phone: ______

I request Providence Health Services (PH&S) restrict the use or disclosure of my protected health information (PHI) in the following manner:

______

I want the limits to apply to the following person/entity (for example, a spouse):

______

I understand PH&S may deny my request. My information is not restricted until I have received written confirmation that PH&S has agreed to my request. If the restriction is agreed to PH&S will continue to disclose my information in the following situations:

- For continuation and coordination of my care.
- When the law requires the use or disclosure of restricted information.
- When I authorize you in writing to use or disclose restricted information.
- For health agency oversight activities

Sign Here: ______ Date: ______

If personal representative signs this request on behalf of the patient, complete the

Print Name: ______

Description of personal representative's authority: ______

Relationship to Patient: ☐ Power of Attorney for Healthcare* ☐ Legal guardian* ☐ Parent ☐ Other

*Attach legal documentation if you are the legal guardian or Power of Attorney for Health care

For Internal Use Only

Date Received:______ Initials ______ MRN______

Sent to: ______ Date: ______

◯ Restriction Accepted. Corresponded with patient/representative on this date: ______

◯ Denied: Reason: ______