I hereby request a restriction or limitation on my medical information used or disclosed during treatment, payment or health care operations. I understand that this request, if approved, will be communicated appropriately within the UAB Medical West. I understand that if this request is denied, I have the right to escalate the request as defined by UABMW procedures. UABMW cannot be held responsible for this requested restriction until such time as the request is approved. No restrictions or limitations will be approved that are in conflict with current laws. In addition, emergency patient situations may override any approved restrictions and/or limitations. I understand the Entity Coordinator will notify me regarding the status of my request within 48 hours of receiving the Request Form.

Patient name: _________________________________ M/R Number: _____________________________

Specific description of requested information restriction/limitation:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Specific persons/organizations requested to be restricted from medical information:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Purpose of Restriction or Limitation:

____________________________________________________________________________________

____________________________________________________________________________________

Request for confidential communication to be sent to the following:

Expiration Date or Event (such as discharge date): ____________

The patient or the patient’s representative must read and initial the following statements:

I understand that, if request is approved, the restrictions and/or limitations will go into effect only when the request is officially approved. I understand that I may revoke this Request at any time by notifying the UABMW Entity Coordinator in writing. This revocation will be applicable from the actual date/time received.

Initials: ____________

I understand that UABMW may deny or conditionally approve my requested restriction based on UABMW’s’ ability to reasonably accommodate the restriction without compromising its ability to provide treatment, secure payment and maintain appropriate operations. Examples of these conditions are as follows:

- participating in research projects can be conditioned on my not requesting restrictions/limitations to use and disclose PHI in the research
- initial enrollment in health plans can be conditioned on not requesting restrictions/limitations for the health plan to review PHI to make eligibility determinations
- furnishing healthcare services to me at the request of a third party can be conditioned on my not requesting restrictions/limitation for disclosure of the PHI to the third party requesting the treatment

Initials: ____________

Signature of patient or patient’s representative: _____________________________ Date:___________

Printed Name of patient’s representative: _________________________________

Relationship to patient: _________________________________

Patient name: _________________________________ M/R Number: _____________________________
UAB MEDICAL WEST
USE OR DISCLOSURE OF INFORMATION RESTRICTION REQUEST

Status of Request:

Entity Coordinator:

☐ Approved     Date: __________  ☐ Denied     Date: __________  Date Patient Notified: ________
Comments: ____________________________________________________________

Current Attending Physician:

☐ Approved     Date: __________  ☐ Denied     Date: __________  Date Patient Notified: ________
Comments: ____________________________________________________________

Privacy Official:

☐ Approved     Date: __________  ☐ Denied     Date: __________  Date Patient Notified: ________
Comments: ____________________________________________________________

Office of Chief of Staff:

☐ Approved     Date: __________  ☐ Denied     Date: __________  Date Patient Notified: ________
Comments: ____________________________________________________________

Signature of Entity Coordinator: _______________________________ Date: __________

Signature of Attending Physician: _______________________________ Date: __________

Signature of Privacy Official: _______________________________
(if applicable) Date: __________

Signature of Chief of Staff: _______________________________
(if applicable) Date: __________