

Health Care Component: _____

Unit Privacy Officer: _____

Restriction Request Form for Protected Health Information

Instructions: Sections 1-3 must be completed. Please print and sign the form.

Section1: PATIENT IDENTIFICATION

Print Name: _____

Street Address, City, State & Zip Code: _____

Patient's Social Security Number: _____

Date of Birth: ____ / ____ / ____

Section 2: RIGHT TO REQUEST INFORMATION

I understand I have the right to request a restriction of how the Missouri State Health Care Component _____ uses and discloses my protected health information. I understand that _____ will make every reasonable effort to agree to the restriction(s) requested regarding my protected health information.

Pursuant to that right, I hereby request _____ to make every reasonable effort to restrict use and disclosure of my protected health information as follows:

Please indicate the individual care provider or any legal representation to which you are requesting access be denied by name and relationship to patient:

Section 3: RIGHT OF DENIAL

I understand _____ has the right to deny my request for a restriction on the use and disclosure of my protected health information to the extent allowed by law. I also understand that _____ may deny my request for amendment if it is not in writing or does not include a reason to support the request.

Signature of Patient
(If under 18 years of age-Parent, Legal Guardian, or Legal Representative)

____/____/____
Date

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1: _____

FOR Missouri State USE ONLY

Section 4: **RESPONSE TO REQUEST** Date Received: _____ Initials: _____

Amendment has been: ☐ GRANTED ☐ DENIED

If granted, provide any circumstances upon which restriction will expire, if any: _____

If denied, please explain reason for denial: _____

Other Comments: _____

COMPLETED COPY OF THIS FORM WAS PROVIDED TO PATIENT (OR PERSONAL REPRESENTATIVE) _____ ON DATE _____

Signature of Unit Privacy Officer, or Designee

____/____/____
Date

A copy of this form will be filed in the above-named patient's PHI.

HIPAA Procedure 1.020, Form 1