REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

You have the right to request that _____ (*name of therapist/practice*) restrict the use and disclosure of your protected health information (PHI). You may ask _____ (*name of therapist/practice*) not to use or disclose any part of your PHI for purposes of treatment or payment.

You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions requested, and to whom you want the restriction to apply, as shown below. _____ (*Name of therapist/practice*) is not required to agree to a restriction you request. Exceptions include situations where [*I/we*] need to use or disclose the information to provide emergency treatment to you, or if the law requires its disclosure.

_____ *(name of therapist/practice*) must agree not to disclose your PHI to your insurance carrier if the disclosure is for payment of treatment and relates to a service which you paid in full, out of pocket. If _____ *(name of therapist/practice*) agree(s) to the requested restriction, [*I/we*] may not use or disclose your PHI unless it is needed to provide emergency treatment.

_____ *(name of therapist/practice*) reserve(s) the right to terminate your requested restriction if you agree to it in writing or verbally, or if you request the termination yourself.

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number (daytime): _____

Description of PHI to be restricted:

_____

_____

_____

State the restriction you want to apply to the PHI.

_____

_____

_____

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Provide the names of persons/organization to be restricted from uses/disclosure.

_____

_____

_____

Client Printed Name _____

Client Signature _____ Date _____

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