COMMUNITY HEALTH SERVICES OF LAMOILLE VALLEY®

Request for Restriction on Use & Disclosure of Protected Health Information

Patient Information

Patient Name:	Requested Date: ____/____/____
Street Address:	Birth Date:
City/State/Zip:	Telephone #:
Patient's Personal Representative Name:	

Requested Restriction on Use and/or Disclosure

I hereby request that CHSLV restrict the Use & Disclosure of my health information in the following manner:

Please specify the type of health information and the requested restriction:

ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION

I understand that CHSLV does not have to agree to my requested restriction(s) unless this request is to restrict disclosures made for payment or health care operations and you have PAID IN FULL for services rendered.

If CHSLV agrees to the requested restriction then the restriction is in effect until one of the following events occurs:

- ❑ I agree to or request in writing that the restriction be terminated; or
- ❑ CHSLV notifies me in writing that they are terminating restrictions, in which case the termination is effective for all PHI created or received on or after the date of the letter.

Date: ____/____/____

Signature of Patient/Representative _____

Printed Name of Patient/Representative_____

FOR CHSLV INTERNAL USE ONLY

Date Request Received: ____/____/____	❑ Restriction Accepted ❑ Services Paid in Full	❑ Restriction Denied

If denied, list reason(s) for denial:

- ❑ Individual was informed of decision in writing on ____/____/____
- ❑ Individual terminated this agreement on ____/____/____
- ❑ CHSLV terminated this agreement. Written notice sent on ____/____/____

_____ ____/_____/____

Signature of CHSLV Privacy & Security Officer Date