PINE CREEK MEDICAL CENTER

Patient Request to Restrict Uses and Disclosures of Protected Health Information

Name_____ Date_____

Address_____ SSN_____

_____ Phone_____

I understand that I have the right to request ("the Request") that Pine Creek Medical Center NOT discloses certain aspects of my Protected Health Information (the "Restricted Information"). I understand that Pine Creek's decision with regard to this Request is completely discretionary and Pine Creek IS NOT REQUIRED to agree to any Request, except when your request is that Pine Creek not disclose your health information to a health plan if you have paid for the health care item or service out of pocket, in full. I understand that if Pine Creek agrees to the Request (the Agreement"), then Pine Creek Medical Center will not be permitted to use or disclose the Restricted Information in violation of the Agreement. I understand that even if Pine Creek agrees to the request, there may be circumstances in which the hospital will be permitted or required by law to use or disclose the Restricted Information, including but not limited to, for my own emergency treatment, for law enforcement purposes, public health activities, health oversight activities and certain purposes.

I hereby request Pine Creek Medical Center NOT use or disclose the following Restricted Information for TPO Purposes or Special Purposes. *(Please be specific)*

_____
_____
_____
_____

NOTE: Hospital will continue to use or disclose your Protected Health Information until the hospital makes a determination of whether to agree or not to agree to the Request. You will be notified via regular mail of such determination.

*Signature*_____

FOR HOSPITAL USE ONLY

HOSPITAL HEREBY: [ ] AGREES [ ] DOES NOT AGREE

IF HOSPITAL DOES NOT AGREE, PLEASE PROVIDE AN EXPLANATION:

_____
_____
_____

*Signature*_____ *Print Name* _____

*Title*_____ *Date*_____

Revised 10/1/2012