

OWYHEE COMMUNITY HEALTH FACILITY REQUEST FOR RESTRICTION(S)

I understand that I have the right to request restriction(s) as to how my protected health information may be used and/or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in my care. I understand that OCHF may not be required to agree to the restriction(s) requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If OCHF agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, OCHF will request the provider not to further use and/or disclose that information.

I request the following restriction(s) on the use and/or disclosure of my protected health information:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE <i>(If Personal Representative, state relationship to patient)</i>	DATE
SIGNATURE OF WITNESS <i>(If signature of patient is a thumbprint or mark)</i>	DATE
<input type="checkbox"/> ACCEPTED <input type="checkbox"/> DENIED	If accepted, state which of the restriction(s) accepted:
SIGNATURE OF THA OR DESIGNEE	DATE

PATIENT IDENTIFICATION:

NAME <i>(Last, First, MI)</i>	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH