Division: NC/GA Division	Area-Entity: All	Dept.: Health Information Management
Origin Date: 01/01/2020	Effective Date: 11/07/2025	

Patient Request for Protected Health Information Release Restriction

Patients have a right to request a restriction for:

1. **Uses and disclosures to carry out treatment, payment, or health care operations**
2. **Disclosure for involvement in the individual's care (family member, friend or other individual identified by the patient as being involved in the patient's health care or payment of health care)**
3. **Disclosures for notification purposes (a family member, personal representative, or another person responsible for the care of the patient's location, general condition, or death)**
4. **Disclosures to public or private entities authorized to assist in disaster relief efforts**

If the request is not for one of the above reasons, this form and the restriction process does not apply.

Section 1: Patient Information

Name of Patient

Date of Birth ( ) Telephone Number

Address

City/State/Zip

Section 2: Information to be Restricted:

I am requesting a restriction on the use/disclosure of my health information in the manner described below. I understand that Advocate Health may deny this request for any reason. I understand that Advocate Health will document this restriction to the best of its ability within the records controlled by Advocate Health. If my request is approved, I understand that the restriction will not apply in case of an emergency. This request will be effective indefinitely unless otherwise indicated by the individual requesting the restriction.

1. Please explain and describe the restriction on the uses and disclosures of your health information (dates of specific health information to be restricted; specific visits):

2. List the Persons/Organizations that you do NOT want information disclosed to:

Section 3: Signature of Authorized Individual

Preferred Contact Method for Restriction Communications

□ **Patient Portal** □ **Mail to address above** □ **Encrypted Email**

Date:_____ **Email Address:** _____

Signature of Patient or Patient's Legal Representative: _____

Section 4: For Office Use Only

Date Received:_____ Accepted ☐ Denied ☐

If denied, reason for denial:

_____ The restriction prohibits the use of protected health information by a physician or workforce member involved in the individual's care.

_____ Information is available or will become available in a computer system that would conflict with the restriction.

_____ Adherence to the restriction cannot be guaranteed.

_____ The request will prevent Advocate Health from receiving payment for services.

_____ Other _____

☐ Individual was informed of acceptance/denial in writing (attach letter of communication)

Date **Time** **Signature/Title of Staff Member**

Return to: **medicalrecordsroi@advocatehealth.org** or Atrium Health P.O. Box 32861 Charlotte, NC 28232

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Atrium Health

Place Patient Label Here