REQUEST FOR RESTRICTIONS OF PROTECTED HEALTH INFORMATION FORM

Patient Name _____

Date of Birth _____

Last 4 digits of Social Security Number _____

Address: _____

Phone Number _____

Medical Record Number _____

Addressograph or Label - Patient Name, Medical Record Number

I am requesting the following restriction(s):

- ❑ **Restriction of record release to a Payer**
- ❑ **Restriction of record release to an Attorney**
- ❑ **Restriction of record release to a Family member/s**
- ❑ **Restriction of record release to a health information exchange (i.e. HealthShare Exchange, Care Everywhere, etc)**
- ❑ **Other: The information I wish to restrict is: (Please specify)**

_____

_____

Thomas Jefferson University (TJU), Thomas Jefferson University Hospitals, Inc. ("TJUH"), Jefferson University Physicians (JUP), and TJUH System (Collectively referred to as Jefferson) participates in Health Information Exchanges (HIEs) which, through secure connected networks with health care providers who participate in the HIEs, makes it possible for us to electronically share protected health information to coordinate patient care. We may electronically share your medical information through HIEs, among participating HIE members for the purposes of treatment, payment, health care operations, and other authorized purposes, to the extent permitted by law.

You have the right to ask Jefferson to restrict the use and disclosure of your protected health information (PHI) for Treatment, Payment or Health Care Operations except for uses or disclosures required by law. You have the right to ask Jefferson to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care. You also have to right to restrict the use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request **must** be in writing.

Jefferson is not required to agree to your request and is not permitted to grant restrictions that violate the law. If Jefferson agrees to your request, then we will be bound by the restriction unless the restriction is later ended by (i) your written request; (ii) by agreement between you and Jefferson (including an oral agreement); or (iii) by Jefferson for health information created or received after you are notified that Jefferson has removed the restrictions. Jefferson may also release the restricted information if you require emergency treatment, or to comply with the law.

If you checked the box labeled "Other", Jefferson will review your request and provide you with a written response. Depending upon the nature your request, it may take several days to respond. Until your request has been accepted, Jefferson will use and disclose your health information in a manner consistent with our Notice of Privacy Practices and applicable law.

Patient Signature: _____ Date _____

If other than the patient, specify relationship _____

If document is interpreted

_____	_____	_____
Interpreter Signature	***Print Name***	***Language***
_____	_____	_____
Date	***Position***	***Relationship to Patient***

After you have completed this form, please return it to the Privacy Office by mail or fax transmission at the following address:

Jefferson Health – Center City
834 Chestnut Street, Suite 450
Philadelphia, PA 19107
Attn: Privacy Office
215-503-6300 (t)
215-503-2213 (f)