I _____, hereby request that the following restriction(s) be placed on the uses and disclosures of my personal health information by _____ (list location).

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment, insurance, or the business operations of OhioHealth.

Please list restrictions requested:

_____

_____

_____

_____

_____

_____

I understand that OhioHealth is not required to agree to my restriction requests, but that OhioHealth is only required to attempt to accommodate reasonable requests when appropriate. Further, I understand that OhioHealth reserves the right to terminate an agreed to restriction if it feels that termination is appropriate. If I wish to terminate any agreed to restriction, I must send a written termination notice to the attention of the OhioHealth Privacy Officer, 180 East Broad Street, Columbus, Ohio 43214.

_____ _____

Patient Name Date of Birth

_____

Medical Record Number

_____

Name of personal representative (if applicable)

_____

Relationship of personal representative

_____ _____

Signature of patient (or patient's representative) Date

Please send a copy to Ethics and Compliance.

OhioHealth

1HIPAA

PATIENT REQUEST TO RESTRICT USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

PATIENT IDENTIFICATION LABEL