Request for Restriction of Use and Disclosure of Protected Health Information

Request for Confidential Communication

Patient Name _____ Today's Date _____

Patient Address _____

City _____ State_____ Zip_____

Patient Phone _____ Patient Date of Birth_____Last 4 digits of SSN _____

☐ **Request Restriction of Use and Disclosure**

You can request a restriction on how Health First, Inc. may use and/or disclose (share) your protected health information (PHI) for treatment, payment or healthcare operations. **Health First, Inc. will make reasonable efforts to honor your request. You will be notified in writing as to whether your request has been accepted or denied.** This restriction will apply only to the date(s) of service specified below:

Date(s) of treatment_____ Location of treatment _____

Describe the PHI you are requesting to be restricted (for example: lab results) _____

_____

Specify the healthcare provider(s) or organizations that you are requesting to be restricted from uses/disclosures of you PHI:

_____

☐ **Confidential Communication**

You can request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Indicate your preferred communication method below:

☐ Home Phone _____ ☐ Cell Phone _____

☐ Work Phone _____ ☐ Email _____

☐ Home mailing address above

☐ Alternative mailing address _____

City _____ State_____ Zip_____

NOTE: If Health First, Inc. agrees to a restriction of uses/disclosures or confidential communications, there may be instances which will require us to contact you for clarification. In the event of an emergency, Health First, Inc. will use and/or disclose the information you are restricting when needed to provide you care and treatment.

Patient/Legal Representative's Signature_____Date_____

Legal Representative's Printed Name_____Relationship to Patient _____

Mail or fax completed form to one of the main Health Information Management Department locations:

Health First's Holmes Regional Medical Center	**Health First Medical Group**
1350 S. Hickory St., Melbourne, FL 32901	730 Malabar Road., Malabar, FL 32950
Phone 321.434.7169 | **Fax** 321.434.5239	**Phone** 321.549.0695 | **Fax** 321.724.8069

FOR OFFICE USE ONLY: (1) Request verified and processed by: Universal ID _____ Date _____

(2) Request verified and processed by: Universal ID _____ Date _____

Request has been made: ☐ Granted ☐ Partially Granted ☐ Denied

Form of ID presented for verification: ☐ Driver's License ☐ Government ID ☐ Other (specify)_____