NEMOURS CHILDREN'S HEALTH

* 1 0 0 1 1 8 *

Patient Name:
MRN:
DOB:

Request for Restriction on Uses & Disclosures of Protected Health Information

Please complete the following information: **Date:** _____

Patient's Address: _____

1. **Date(s) of Encounter to be held as Restricted:** _____
2. **Type of Encounter(s) to be held as Restricted:** _____
3. **Listing of Ancillary Service(s) to be held as Restricted:** _____
4. **From whom should this information be restricted:** _____

	List Specific Tests/Encounters	List the Date of the Tests
☐ **Clinical (Lab) Test:**	_____	_____
☐ **Medical Imaging (x-ray)Test**	_____	_____
☐ **Behavioral Health Reports**	_____	_____
☐ **Therapy reports**	_____	_____
☐ **Other**	_____	_____

5. **Name of the Healthcare Provider(s) who was seen at the time of the Encounter:**
   _____ _____
   _____ _____

I understand that I have the right to request that Nemours restrict their use and disclosure of my protected health information (PHI). This means that I may ask Nemours not to use or disclose any part of my PHI for purposes of treatment, payment, or health care operations. I may also request that any part of my PHI not be disclosed to family members or friends who may be involved in my care. I also understand that Nemours is not required to agree to the restriction that I request.

I understand that Nemours must agree not to disclose my PHI to my health plan if the disclosure is for payment or health care operations and relates to a health care item or service, which I paid for in full, out of pocket. I also understand that if Nemours agrees to the requested restriction, Nemours may not use or disclose my PHI in violation of the restriction unless it is needed to provide emergency treatment or the law mandates such use or disclosure. Finally, I understand that I can terminate the restriction at any time, in writing, and that Nemours can terminate this agreement upon written notification to the patient or Legal Representative.

_____	_____	_____	_____ AM
Patient / Legal Representative's Signature	**Print Name**	**Date**	**Time** PM

INTERPRETER'S SIGNATURE: (To be completed only when appropriate)

I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

_____	_____	_____	_____ AM
Interpreter's Signature &/or Telephone Identification Number	Print Name	Date	Time PM

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

Request for Restriction on Uses & Disclosures of Protected Health Information

To be completed by Nemours

Restriction has been: ☐ **Accepted** ☐ **Denied (If denied, check the reason for denial):**

- ☐ **Upon recommendation of the Health care Provider**
- ☐ **Upon recommendation of the Operational Review Team**
- ☐ **Federal/State law prohibits the restriction**

Comments by the Healthcare Provider:

_____
_____
_____
_____
_____

Comments by the Operational Review Team:

_____
_____
_____
_____
_____

Request for Restriction has been reviewed by the following:

_____	_____	_____	_____AM
Reviewer's Signature	**Please Print Name**	**Date**	**Time PM**
_____	_____	_____	_____AM
Reviewer's Signature	**Please Print Name**	**Date**	**Time PM**

Notification was sent to:

	Who received notice	**Date Sent**
☐ **Patient/Legal Representative**	_____	_____
☐ **Provider**	_____	_____
☐ **Scheduling**	_____	_____
☐ **Central Billing Office (CBO)**	_____	_____
☐ **Medical Imaging**	_____	_____
☐ **Clinical Lab**	_____	_____
☐ **Other**	_____	_____

_____	_____	
Signature of Staff Member	**Please Print Name**	
_____	_____	_____AM
Please Print Title	**Date**	**Time PM**

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware; Nemours Children's Hospital, Florida; Nemours Children's Hospital, Surgery Center, Bryn Mawr; and Nemours Children's Hospital, Surgery Center, Deptford; and all entities operating under the name Nemours Children's Health.