Saint Luke's Health System

Request for Limitations and/or Restrictions on Uses and Disclosures of Protected Health Information

Complete this form and submit to the Health Information Management Department.

1. **Patient's Name:** ____

2. **Address:** ____

   City: ________________________________ **State:** __________ **Zip:** ___________

3. **Date of Birth:** ________________________________

4. **Date of Request:** _____________________________

5. **Describe the Restriction:** ____

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6. You have the right to request a restriction on our uses and disclosures of your information for the purposes of treatment, payment, and health care operations. You may also restrict disclosures we make to family members or others involved in your care or in payment of your care. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request, we will notify you in writing.

7. By submitting this form, I hereby request the organization to restrict uses and disclosures of my health information as described above. I understand and acknowledge that the organization is not required to agree to my request.

____ ____________________
Signature of Patient or Legal Representative *Date Notice Effective*

____
Print Patient Name

8. **For Organizational Use Only**

Request: Approved ☐ Denied ☐ Not Applicable ☐

____ ____________________
Signature of Reviewer *Date*

Original: File in Medical Record