CenterWell Senior Primary Care

6350 West Colonial Drive
Orlando, FL 32818
PH: 866-222-0403

Request for Restriction or Termination of Restriction on Uses and Disclosure of Protected Health Information (PHI)

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

I understand that by signing and submitting this form, I am hereby requesting the name of the clinic below to restriction on the use and disclosure or my protected health information.

_____

Name of Clinic

I understand the following:

♦ This restriction will not apply to any disclosures of PHI that occurred prior to implementation of this request.	♦ Restrictions will not apply when the restricted information is needed for emergency treatment.
♦ You may request termination of a previous restriction at any time.	♦ Restrictions cannot apply to workers' compensation.
♦ We may voluntarily agree to other requests for restrictions. Any restrictions to which we have voluntarily agreed may be terminated by informing you of the termination.	
♦ We are not required to agree to this restriction request, unless it is to restrict disclosure of your PHI to a health plan or carrier for treatment or services for which **you have paid in full**. We may remove the restriction if your payment is not honored.	

Request: ☐ Place a Restriction ☐ Remove a previous restriction

Date of Service: _____

Description of information to be restricted _____

_____

Name of Individual /Entity to whom PHI should not be disclosed:

_____

Other: _____

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Print Name _____ Date _____

Signature _____

Name of Interpreter/Translator (if required) _____ Phone Number _____

***If a translator or interpreter was required.**

OFFICE USE ONLY

Notice of Decision

Restriction(s) Status:

☐ We have accepted the restriction(s) as requested.

☐ We have accepted only the following portion of the restriction(s):

_____

_____

Termination of Restriction:

☐ Termination requested on previous restriction has been completed

Effective Date: _____

☐ We are informing you that the current restrictions are being terminated

Effective Date: _____

Date request was received: _____

Date request was processed/completed: _____

Facility Name _____

Office Personnel (Print Name) _____ Date _____

Office Personnel Signature _____