**REQUEST FOR RESTRICTION(S) OF**

**PROTECTED HEALTH INFORMATION**

|  |  |  |
| --- | --- | --- |
| *Patient Name* | *Date of Birth* | *MRN* |

I understand that I have the right to request restriction(s) as to how my protected health information may be used and/or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in my care. I understand that the Health & Wellness Department of the Pueblo of San Felipe may not be required to agree to the restriction(s) requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If the Health & Wellness Department of the Pueblo of San Felipe agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, the provider(s) of the Health & Wellness Department will request the recipient not to further use and/or disclose that information.

**I request the following restriction(s) on the use and/or disclosure of my protected health information:**

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**I request restriction of disclosure of my protected health information to the following facility/individual/organization:**

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| --- | --- |
| SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE *(If Authorized Representative, state relationship)* | DATE |
| SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* | DATE |

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_ ACCEPTED \_\_\_\_\_ DENIED | If accepted, state which of the restriction(s) accepted: | |
| SIGNATURE OF DEPARTMENT DIRECTOR/PRIVACY OFFICER/DESIGNEE | | DATE |

**HIIM Statement**

*Public reporting burden for this request is estimated to average 30 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, this request unless there is a valid signature and/or authorization from the patient. Please send comments regarding this burden estimate or any other aspect of this request, including suggestions for reducing this burden to the:*

*Privacy & Compliance Officer*

*Health & Wellness Department*

*3 Cedar Road*

*San Felipe Pueblo, NM 87001*

*Email: inunez@sfpueblo.com*