NH2541

NORTHSIDE HOSPITAL

English - Spanish - Korean

AFFIX PATIENT LABEL HERE

Name of Hospital or Physician Practice:

_____

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

_____

You may request a restriction on the use and/or disclosure of your health information. However, we are not required to agree to your request. No restriction is effective until you receive written confirmation. ***In emergency treatment situations, restrictions requests will not apply.***

I hereby request that the following PHI to be restricted or limited by the Northside Hospital: (Please check all that apply)

- ☐ Home Phone #
- ☐ Home address
- ☐ Occupation
- ☐ Name of employer
- ☐ Date of Service
- ☐ Physician notes
- ☐ Prescription information
- ☐ Patient History
- ☐ Office address
- ☐ Office phone #
- ☐ Spouse's name
- ☐ Spouse's office phone #
- ☐ Religious Affiliation
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

In what manner would you like to restrict the use and/or disclosure of your health information?

_____

_____

_____ _____

Signature of Patient or Legal Representative Date/Time Reason Patient Unable to Sign

_____

Relationship to Patient If Not the Patient

_____

Interpreter's Signature Date/Time

Note: If remote interpretation used (phone/iPad), record interpreter name, ID#

Interpreter Comments (optional): _____

_____

Please complete this form and submit to HISINTERNALSUPPORT@NORTHSIDE.COM

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____

Reorder #NH2541 **U**
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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Original: Chart