HENRY FORD HEALTH℠

Request to Restrict the Use and/or Disclosure of Patient Information

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

As a patient, you have the right to request that Henry Ford Health (HFH) restrict the use or disclosure of your patient information, including for treatment, payment or our health care operations (TPO).

Restriction Agreements May Not Apply In Emergency Situations Or When Required By Law. Be mindful that under certain circumstances, HFH may approve or deny your request.

When completed, please mail form to: Henry Ford Health, Information Privacy & Security Office, One Ford Place, Detroit, MI 48202 or Fax (313) 874-9449 or email IPSO@hfhs.org . If you choose to email this form, please be aware that email may not be secure and your information could be viewed while in transit.

This form **must** be signed and dated; incomplete forms will be returned to you unprocessed. You will be notified in writing when your request has been processed. If you choose to cancel your restriction, please contact the Information Privacy & Security Office using the contact information above.

REQUESTOR INFORMATION

If the requestor is the personal representative, please attach certifying documentation of your status as the personal representative, such as a Durable Medical Power of Attorney or Guardianship documents.

Patient: _____ _____ _____
(Name of Patient) Medical Record Number Date of Birth

Requested by (if other than patient): _____ _____
(Personal Representative of Patient) (Relationship to Patient)

Patient/Requestor Contact Information: _____ _____
(Street Address) (City/State/Zip code Telephone

Patient/Requestor Signature: _____ **Date:** _____

Please specify the type of patient information you would like restricted in the sections below as applicable. You will receive a letter notifying you whether your restriction has been approved or denied.

If approved, the restriction will be effective on the date specified in the written confirmation from HFH.

SECTION A – RESTRICT DISCLOSURES TO CAREGIVERS

Unless you object in writing, we may disclose your patient information to a friend, family member or other caregiver who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your location of care, general condition or death. We may disclose your patient information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you are unable or unavailable to opt in or out of these disclosures, we will use our best judgment in communicating with your family and others.

☐ I hereby request that my patient information **not** be disclosed to caregivers involved in my care or who help pay for my care.

☐ I hereby request that my information **not** be disclosed for notification purposes or for disaster relief efforts.

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SECTION B – RESTRICTION OF OTHER DISCLOSURES

☐ **Do not share my information for treatment purposes.**

☐ **Do not submit my patient information to my insurance company, I am a self-pay patient and paid for the service dates below in full at the time of service.**

Relevant Dates of Service: _____

Insurance Carrier (s): _____

☐ **Restrict access to my Patient Information from the following HFH Employee(s):**

_____

☐ **Place the following password/PIN on my account** (used for verification of identity purposes) _____

☐ **Other** _____

FOR HFH IPSO USE ONLY

Received By: _____ Date Received:_____Date forwarded to HIM scanning: _____
(Initials)

Date of Patient Response Letter _____