REQUESTING A RESTRICTION OF PATIENT INFORMATION FORM

As a patient, you have the right to request that Henry Ford Health System (HFHS) 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, HFHS may approve or deny your request.

When completed, please mail form to: Henry Ford Health System, Information Privacy & Security Office, One Ford Place, Suite 2A, 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 is not encrypted 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.

☐ **Disclosures to Caregivers** (Section A) ☐ **Other Restriction Requests** (Section B)

REQUESTER 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 papers.

Patient: ______________________________ ______________ ______________
(Name of Patient) Medical Record Number Date of Birth

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

Requestor Contact Information: ______________________________ ______________
(Street Address) (City/State/Zip) (Telephone)

Patient/Requestor Signature: ______________________________ **Date:** ______________

RESTRICTION REQUEST- 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 helps pay for my care.

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

RESTRICTION REQUEST- SECTION B – RESTRICT OTHER DISCLOSURES

Please specify the type of patient information you would like restricted. Restriction is effective from the date you receive written confirmation from HFHS of the approval of your request.

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

☐ **Do not submit my patient information to my insurance company, I am a self-pay patient.**

Relevant Dates of Service: ______________________________

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

____

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

FOR HFHS USE ONLY

For IPSO Use Only

Received By: ____________ Date Received: ______________ Date forwarded to Medical Records: ______________
(Initials)

For HIM Use Only

Outcome: ☐ Denied ☐ Approved Date Response Letter Sent to Patient: _____________

Date scanned/Inserted into medical record or file: ______________