Request for Restrictions on Use and Disclosure of Health Information

Your Rights

You have the right under HIPAA to ask us not to use or share your health information for treatment, payment, and business purposes. This is known as a request for a restriction.

- **Atrium Health is not required to agree to a restriction.** (With certain exceptions.)
- **No restriction is effective until you receive written confirmation from Atrium Health.**
- If we agree to a restriction, the restriction will be effective for the current specific patient visit or encounter specified and for future treatment, payment, or business purposes.
- **In the event of an emergency situation, restriction agreements will not apply.**
- You may ask us at any time to end this restriction by telling us verbally or putting it in writing.
- We may end our agreement to the restriction by informing you in writing. This will only affect health information created or received after we have so informed you.

To request a restriction, complete this form in its entirety and submit it to Atrium Health Corporate HIM P.O. Box 32861, Charlotte, NC 28231-2861

Restriction on Use and Disclosure of Health Information

Name:____ Date of Birth: ________________________________

Street Address:

____

City, State, Zip Code:

____

Please specify the facility or practice from which you are requesting a restriction:

____

Please describe the information to which this request applies (e.g., pregnancy test results):

____

____

Do not release my health information to the following person(s):

____

Signature of Patient or Representative:

____Date:______________________________

If signing as authorized representative, describe your authority to act for the patient, and submit documentation showing such authority, as appropriate:

____

For Atrium Health Use Only

______ Request for restriction has been **denied.** (Note: The Facility may not deny a request for restriction from the Facility Directory.)

Please note reason for denial:

____

____

_____ Request for restriction has been **accepted**. In the case of an emergency or if necessary to comply with the law, the restriction agreement will not apply.

Signature(s):____Date: ______________________

Print Name & Title:

____

Comments: ____

Rev. Jan 2020

910

Place Patient Label Here