REQUEST TO RESTRICT PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: ______________________________ **Date of Birth:** ______________
Last First Middle (M/D/Y)

Address: ____
Street City State Zip

Date of Request: ___________ **Physician:** ____________________ **Practice:** ____________________

Telephone Number Where You Can Be Reached: ______________________________

I understand that I have the right to restrict how COPC uses and discloses my PHI except for those uses and disclosures that are required by law. I also understand that COPC has the right to deny my request to restrict PHI and that I will be notified, in writing, of the denial decision.

☐ **Restrict the information from my service/item on ____________ to my health plan because I have paid out of pocket and in full for this service/item.**

☐ **Restrict the following information:** ______________________________

Restrict access to the following:

____________________ ______________________________
Name Address City State Zip

____________________ ______________________________
Name Address City State Zip

Effective Date of This Restriction: ____________________ **Date Restriction is To End:** ____________________
(M/D/Y) (M/D/Y)

______________________________ ____________________
Signature of Patient **Date**

______________________________ ____________________ ____________________
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

For COPC Use Only – forward to COPC Compliance Officer

Date Request Received: ____________________ **Restriction Was:** ☐ Accepted ☐ Denied

If denied, check reason(s) for denial:

☐ The Request for Restriction Form was not complete. You may complete the missing information highlighted above and resubmit your request to: COPC Compliance Officer, 570 Polaris Parkway, Suite 250, Westerville, Ohio 43082

☐ The item/service was not paid for out of pocket and in full.

☐ The PHI cannot be restricted as required by law.

Comments: ______________________________

Patient Notified By: ☐ Regular Mail ☐ Courier ☐ Certified Mail **Date Sent:** ____________________

______________________________ __________ ______________________________ __________
Signature of COPC Authorized Representative (Name/Title) **Date** **Signature of Health Care Provider (if applicable)** **Date**

Form Revision: 9/23/2013