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| Route Approval To: | |
| [X] | Billing |
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| ou-logo | **The University of Oklahoma**  Enter Entity Here | Insert College /Department Name  Insert College/Department Street Address  Insert College/Department City State and ZIP |
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**Request for Restrictions on Use and Disclosures of Protected Health Information—Norman Campus**

**NOTICE TO PATIENT:** Your request for a restriction on the use and disclosure of your protected health information is applicable only to the information maintained by the OU Norman Campus. If you would like to request a restriction on the use and disclosure of your protected health information maintained by any other University entity, a separate request must be submitted to that provider. (This request is applicable only to uses and disclosures by the OU Norman Campus.)

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| Last Name: |  | | First: | |  | | | Middle: | | |  | | |
| Other Names Used: |  | | Date of Birth: | | |  | | | | | | | |
| Address: |  | | City: | |  | | State: | |  | | | Zip: |  |
| Home Phone: | ( ) | Alt. Phone: | | | ( ) | | Cell Phone: | | | ( ) | | | |
| I hereby request restrictions on the use and/or disclosure of the following protected health maintained or created by the OU Norman Campus providers named below: | | | | | | | | | | | | | |
| **Information Covered:** | | | | **Restriction:** | | | | | | | | | |
| Entire Health Record | | | | Do Not Disclose to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Pathology/Lab Results for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | | | | | | | | | |
| Billing Records for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Do Not Bill to\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
|  | | | | \* You will be required to pay in full for services at the time they are rendered. | | | | | | | | | |
| **My request applies to the information about health care services that occurred (check one and indicate date(s)):** | | | | | | | | | | | | | |
| 🞏 On this date of service only (indicate date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or | | | | | | | | | | | | | |
| 🞏 From this date of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_until I indicate otherwise, or | | | | | | | | | | | | | |
| 🞏 From this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to this date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | | | | | | | | | | | |
| **Name of Physician Provider:** | | | **Department/ Clinic:** | | | | | | | | | | |
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**Note:** Even if a requested restriction is granted, it cannot prevent complete disclosures, nor will it prevent disclosures required or permitted by law. Disclosures also may be made in case of emergency.

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|  |  | | |  | |  | |  |
| **Signature of Patient, Parent, or Authorized Legal Representative\*** | |  | **Relationship to Patient** | |  | | **Date** | |

**\*May be requested to show proof of representative status**

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| FOR CLINIC USE ONLY: | | |  |  | | | | | |  |
|  | **REQUEST APPROVED** | |  | **REQUEST DENIED\*\*** | | |  | | | |
|  |  | |  | Too expensive to accommodate request | | |  | May prevent effective treatment | | |
|  |  | |  | Administratively impractical to accommodate request\* | | |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| By: | | |  | | |  |  | | |  |  | |
| Clinic/Department Signature | | |  | Title | | | | Date | |

\*\* May not deny the request if the request applies to restricting disclosure to a health plan for payment or health care operations purposes and the disclosure pertains to a service for which payment in full for out-of-pocket amounts due to the provider has been made.