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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 NameInsert College/Department Street AddressInsert 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:** |
|       |       |
|       |       |
|       |       |
|       |       |

**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.