Patients have the right to request a restriction on how MultiCare Health System uses and discloses their protected health information (PHI). You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or payment of your care, like a family member or friend.

Please be as specific as possible when filling out this form.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

List the PHI are requesting not to be used or disclosed. Include dates of service, health care providers, service provided, etc.:

_____

_____

_____

_____

List the person(s) or entities you are requesting your PHI not be released to:

_____

_____

_____

_____

- I understand MHS has up to sixty (60) days to review and respond to my request.
- I understand MHS may deny my request for restriction.
- I understand any restrictions MHS accepts will not apply when the restricted information is needed in an emergency treatment situation.
- I understand any restrictions MHS accepts will not apply when the request is required or permitted by law.
- I understand that if I am requesting a restriction on disclosures to my health plan, I must pay for the item or service in full.
- MHS may terminate the restriction if I agree to or request the restriction be terminated.

_____ _____

Signature of Patient or Personal Representative Date

Patient Identification - Always Attach Patient Label

Name:

MRN#:

CSN#:

Age /Sex:

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

MultiCare

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