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:** ____Tara Yuan, M.D.______ **Practice:** __Pacific Mental Health__

Telephone Number Where You Can Be Reached: ______________________________

I understand that I have the right to restrict how Tara Yuan, M.D./Pacific Mental Health uses and discloses my PHI except for those uses and disclosures that are required by law. I also understand that Tara Yuan, M.D./Pacific Mental Health 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 Pacific Mental Health Office Use Only – forward to Tara Yuan, M.D. Compliance Officer

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

If denied, check reason(s) for denial:

☐ The Request for Restriction Form was not complete.
☐ The item/service was not paid for out of pocket and in full.
☐ The PHI cannot be restricted as required by federal law.

Comments: ____

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

______________________________ ______________________________
Signature of Authorized Representative **Date**

______________________________ ______________________________
Signature of Health Care Provider (if applicable) **Date**

Revised: 2014