RESTRICTION OF USE & DISCLOSURE REQUEST FORM

Name:
Other Name(s):
Address:
Social Security #:
Phone:
Date of Birth:

You have the right to request restriction of the use and/or disclosure of your Protected Health Information (PHI) by Wellplace. If you are asking to limit use or disclosure of such information, please consider the following:

- Wellplace will consider your request, but Wellplace does not have to agree to your request. You will be notified in writing of Wellplace's decision to accept or deny your restriction request. If Wellplace agrees to a restriction, Wellplace may terminate the agreement at any time by giving you written notice.
- Where your authorization is required for the use or disclosure of your Protected Health Information, any restrictions on such use or disclosure will be addressed in the authorization process.
- Protected Health Information that is needed for emergency treatment will be shared regardless of any restriction.
- Protected Health Information that is required by law to be disclosed will be disclosed regardless of any restriction.

I am asking Wellplace to limit the use or disclosure of my Protected Health Information as follows (be specific):
____
____
____
____
____

I am making this request for the following reason (s):______________________________
____
____
____
____
____
____

RESTRICTION OF USE & DISCLOSURE REQUEST FORM

____ ________________

Your signature or Personal Representative's signature Date

____

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE.

Type of authority (e.g., court appointed, custodial parent):______________________________________

For Wellplace Use Only

Approved: ☐ Denied: ☐

State reason(s): ____

Signature: ____

Title: ____

Date:____