**Request for Restrictions on**
**Uses or Disclosures of Protected Health Information**

Washington University will accept for review written requests for certain restrictions on its Use and Disclosures of your Protected Health Information ("PHI") including restrictions on Uses or Disclosures for Treatment, Payment, and Health Care Operations and restrictions on Disclosures to persons involved in your care, such as family or friends. Washington University is not required under federal or state law to agree to abide by any requested restriction except we must agree to your request to restrict disclosure of your health information to your health plan in the disclosure is not required by law and the health information you want restricted pertains solely to a health care item or service for which you (or someone other than your health plan, on your behalf) have paid us for in full at the time the service was provided.

In accordance with federal regulations, requests for restrictions will also not affect Washington University's Use or Disclosure of PHI in certain circumstances such as disclosures for public health activities, to report victims of abuse, neglect or other violence, to the federal or state health departments, or for law enforcement or judicial purposes.

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Request Date: _____

Individual Name: _____

Date of Birth: _____ SSN: _____

Individual Address:_____

Telephone Number: (H)_____ (W)_____

1. I hereby request the following restriction(s) on the internal Use of my PHI by Washington University in connection with my medical treatment, payment or other health care operations: _____
   _____
   _____
   _____
   _____
   _____

2. I hereby request the following restriction(s) on the external Disclosure of my PHI to third parties by Washington University in connection with my medical treatment, payment or other health care operations: _____
_____
_____
_____
_____
_____
3. I understand that Washington University and its members are not required to agree to my requested restriction(s). I further understand that Washington University will not agree to a restriction that prevents uses or disclosures permitted or required as described in the Notice of Privacy Practices.
4. I understand that even if my requested restriction is accepted, Washington University may use or disclose restricted information if such information is necessary to provide me with emergency treatment.
5. I understand that Washington University may terminate an agreed upon restriction, in which case the termination is effective only with respect to PHI created or received after the date that Washington University notifies me of the termination. I further understand that I may terminate an agreed upon restriction orally or in writing.

_____ _____
Signature of Individual or Personal Representative Date

**For Washington University Use Only:**

Date of Response:_____

_____ Restriction Agreed Upon

_____ Restriction Denied

Signature of Staff Person _____ Date _____

Print Name & Title_____