



Patient Name: _____

MRN: _____

DOB: _____

* 100118*

Request for Restriction on Uses & Disclosures of Protected Health Information

Please complete the following information:

Date: _____

1. Date(s) of Encounter to be held as Restricted: _____

2. Type of Encounter(s) to be held as Restricted: _____

3. Listing of Ancillary Service(s) to be held as Restricted: _____

4. From whom should this information be restricted: _____

	List Specific Tests/Encounters	List the Date of the Tests
Clinical (Lab) Test:	_____	_____
Medical Imaging (x-ray) Test	_____	_____
Behavioral Health Reports	_____	_____
Therapy reports	_____	_____
Other	_____	_____

5. Name of the Healthcare Provider(s) who was seen at the time of the Encounter:

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Patient Name:
MRN:
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**Request for Restriction on Uses & Disclosures of
Protected Health Information**

To be completed by Nemours

Restriction has been: **Accepted** **Denied (If denied, check the reason for denial):**
 Upon recommendation of the Health care Provider
 Upon recommendation of the Operational Review Team
 Federal/State law prohibits the restriction

Comments by the Healthcare Provider:

Comments by the Operational Review Team:

Request for Restriction has been reviewed by the following:

Signature	Please Print Name	Date	Time	AM PM
				AM PM

Notification was sent to:

Who received notice

Date Sent

- Patient/Legal Representative**
- Provider**
- Scheduling**
- Central Billing Office (CBO)**
- Medical Imaging**
- Clinical Lab**
- Other**

Signature of Staff Member

Please Print Name

Please Print Title

Date

Time AM
 PM

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and all entities operating under the name