PATIENT'S REQUEST FOR RESTRICTION ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name First Date of Birth (Mo/D/Yr) Medical Record #

Select the DHS facility for which this request for restriction applies

☐ Los Angeles General Medical Center	☐ Rancho Los Amigos National Rehabilitation Center
☐ Olive View Medical Center	☐ High Desert Regional Health Center
☐ Harbor-UCLA Medical Center	☐ Martin Luther King, Jr. Outpatient Center
☐ CHC/Health Center: _____	
☐ Other: _____ Facility Name Street Address City State Zip Code	

1. I understand that DHS may use or disclose my protected health information ("PHI") for the purposes and under the circumstances described in the DHS Notice of Privacy Practices, and that otherwise, DHS must not use or disclose my PHI.
2. I understand that I may request DHS to refrain from certain uses or disclosures of my PHI that the law would otherwise allow. Specifically, I understand that I may request DHS to refrain from using or disclosing my PHI for any of the following purposes:
   a. For my treatment;
   b. To obtain payment for services rendered to me;
   c. For its various "health care operations", as defined by federal law;
   d. If I am an inpatient and do not object, to provide very limited information about my location and general status from its facility directory to persons who ask for me by name and to members of the clergy;
   e. If I do not object, to family members, individuals involved in my care or payment for my care; and
   f. If I do not object, to disaster relief agencies.
3. I also understand that even though I have the right to ask that DHS not make one or more of these disclosures, DHS does not have to agree to my request.
4. If you ask us to restrict our uses and disclosures of your PHI even more than the law requires, and if we agree to do so, we are required to honor that agreement. DHS will notify you in writing as to whether or not your restriction request was approved or denied. Until a decision is made, DHS will continue to use and disclose your PHI as allowed or required by law.
5. I hereby request that DHS agree to limit its use or disclosure of my PHI as follows:
   a. The information I want to have specially protected is:

      _____

      _____

      _____

   b. I want to limit:
      ☐ The inside use of this information by DHS (i.e., the communication of this PHI among DHS workforce personnel for otherwise lawful purposes).
      ☐ The outside disclosure of this information by DHS (i.e., the communication of this PHI to persons or organizations outside of DHS, for otherwise lawful purposes).
      ☐ Both the inside use and the outside disclosure of this information.

MRUN

NAME

DOB/GENDER

PATIENT'S REQUEST FOR RESTRICTION ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

c. Complete, only if applicable: I do not want the following person/entity to receive the information described in paragraph 5(a) above: _____

NOTE: If LACDHS agrees to the requested restriction, we may still use or disclose the information in the following circumstances:

- ☐ If you are in need of emergency treatment and the restricted information is needed to provide emergency treatment. In this circumstance, LACDHS may use the restricted protected health information itself or may disclose the restricted protected health information to a health care provider to provide treatment to you. If the restricted protected health information is disclosed to another health care provider for your emergency treatment, LACDHS will ask the health care provider not to further use or disclose the protected health information.
- ☐ For certain public health activities.
- ☐ For reporting abuse, neglect, or domestic violence.
- ☐ For health agency oversight activities, law enforcement purposes and specialized government functions.
- ☐ For judicial or administrative proceedings.
- ☐ For identifying decedents to coroner and medical examiners or determining a cause of death.
- ☐ For organ procurement purposes.
- ☐ For certain research activities.
- ☐ For workers' compensation programs
- ☐ For uses or disclosures otherwise required by law.

d. If an additional restriction is agreed to, it may be terminated if:

- ☐ I request, or agree to, the termination in writing
- ☐ I orally agree to the termination and the oral agreement is documented
- ☐ DHS informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by LACDHS or received by LACDHS after I am notified of the termination

Signature of patient or representative: _____ Date: _____

If representative, give relationship: _____

Approved by: _____ Title: _____ Date: _____
Employee Name

REVOCATION OF RESTRICTION

Signature of patient or representative: _____ Date: _____

If representative, give relationship: _____

Received by: _____ Title: _____ Date: _____
Employee Name

MRUN

NAME

DOB/GENDER

PATIENT'S REQUEST FOR RESTRICTION ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION