AdvantageCare
PHYSICIANS ™

Patient Request to Restrict Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____City/State/ZipCode:_____

Telephone # most easily reached: _____

Please check the correct box:

☐A. I request that AdvantageCare Physicians restrict the use or disclosure of my health information **to my health plan** as follows:

  Describe the information you want restricted including specific date of service(s):

_____
_____

Note- this restriction is only valid for items or services paid for out of pocket in full at the time the service is rendered.

☐B. I request that AdvantageCare Physicians restrict the use or disclosure of my health information as follows:_____

_____
_____
_____

I understand that the information in my medical record may include information relating to sensitive information. State and federal laws protect this sensitive information. If the information applies to you, **please check the information you would like to be restricted**. Provide date(s) if appropriate.

☐	_____Alcohol, drug, or substance abuse records:	Date(s): _____
☐	_____AIDS, HIV testing/results:	Date(s): _____
☐	_____Mental health records:	Date(s): _____
☐	_____Sexually Transmitted Disease records:	Date(s): _____
☐	_____Genetic records:	Date(s): _____
☐	_____Research records:	Date(s): _____

List the specific persons or entities that you want this restriction to apply to:

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

v. 8.23.2018

Patient Request to Restrict the Use or Disclosure of Protected Health Information

By signing this authorization form to restrict the use or disclosure of my medical information, I understand that:

- **Restrictions to a health plan** are only valid for items or services that have been <u>paid in full, out of pocket</u>. AdvantageCare Physicians will not submit a claim to the health plan for services that you have paid in full at the time the service was provided. I need to <u>notify the Patient Service Representative (PSR)</u> when presenting for the visit that I wish to restrict use or disclosure of my information to the health plan, pay for the service(s) in full ("Self-pay"), complete the information requested under "A" above and return it to the PSR at that time. I understand that AdvantageCare Physicians will grant requests for restrictions to health plans only if the service has been paid in full.
- **Restrictions to individuals (family members or others) or other entities (excluding health plans)** require completion of the form, as applicable. AdvantageCare Physicians will review the information to determine whether or not the request will be honored and notify me within 60 days from receipt of the request for restriction.
- I have the right to <u>revoke or modify</u> the restriction at any time. The request must be made in writing and presented to the applicable AdvantageCare Physician medical office or mailed to the Director of Health Information Management at the following address: 55 Water Street, 12th Floor Rm 12G09, New York, NY 10041.
- Restrictions will not apply to information that has already been used or disclosed as part of AdvantageCare Physicians' treatment, payment or operations or pursuant to previous authorizations from me to the individuals and/or entities identified at the time this form is completed.
- Unless otherwise revoked or modified, this restriction will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 6 months from the date signed. Restrictions to health plans do not expire unless I revoke or modify the restriction.
- I understand that signing this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits <u>may not be conditioned</u> on whether I sign this authorization.

_____   _____
Signature Patient or Authorized Representative   Date

_____
Print Name of Patient or Authorized Representative

_____
Relationship to Patient or Authority of Authorized Representative

Completed forms can be given directly to the PSR at time of service or mailed to:
Privacy Officer, 55 Water Street, 12th Floor, Rm 12H92, New York, NY 10041

For AdvantageCare Use Only
Date Received: (MO/DY/YR) ____/____/____
☐   Received by (print):_____
☐   Scanned to HIM by Medical Office
Disposition of Request: _____ Granted   ____Denied (Notify Requestor)
Reason for Denial: _____
If request denied, Requestor notified (MO/DY/YR) ___/___/_____