Patient Request to Restrict Use and/or Disclosure of PHI

Group Health Cooperative
of South Central Wisconsin

PURPOSE:

The purpose of this form is to honor the patient's right to request restrictions to the use and disclosure of their protected health information (PHI) maintained at GHC-SCW.

Patient's Last Name | Patient's First Name | GHC # | Date of Birth

Street Address | City | State | Zip Code

E-Mail Address (if okay to use for this purpose) | Phone Number

RELEASE RESTRICTION

I request that GHC-SCW restrict the use and/or disclosure of my protected health information for purposes of treatment, payment, and/or health care operations, as well as to family members, friends or others involved in my care, in the manner described below. I understand that GHC-SCW may deny this request. If my request is approved, I understand that the restriction will not apply when the restricted information is needed to provide emergency treatment or when disclosure of the information is otherwise required or permitted by law. If approved, restrictions will not apply to disclosures that were processed prior to this release restriction document being submitted.

FEDERAL HIPAA PRIVACY RULES

These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information. You can find a copy of the Notice of Privacy Practices on the website at ghcscw.com. This information is located on the bottom left corner of the website. Click on Notice of Privacy Practices (HIPAA).

Please describe specifically the health information to be restricted and how you would like GHC-SCW to restrict its use or disclosure:

Dates of Specific Health Information to be Restricted: _____

Specific Conditions to be Restricted: _____

_____

Persons/Organizations Restricted from Use/Disclosure: _____

_____

I understand that if GHC-SCW agrees to the restriction, either I or GHC-SCW may terminate this restriction in writing at any time in the future.

SIGNATURE

_____ _____

Patient or Personal Representative Date

Return completed form via one of the below options:

GHC-SCW – ATTN: Privacy Officer
1265 John Q. Hammons Dr.
Madison, WI 53717-1962

Email to privacy@ghcscw.com

Fax (608) 662-4917