ARCHBOLD MEDICAL CENTER
P. O. Box 1018 • Thomasville, GA 31799-1018

Patient label

❑ AMG ❑ AMH ❑ BCH ❑ GGH ❑ MCH

Patient Request for Restriction on Uses and Disclosures of Protected Health Information

Please fill in all of the following information:

Patient Name: _____

Birth Date: _____

Patient Address: _____

_____

Home Phone Number: _____ Work Phone Number: _____

Date of Request: _____

I request Archbold Medical Center to restrict its uses and disclosures of my Protected Health Information as specified below.

Check all that apply:

❑ Treatment, Payment or Health Care Operations: I request Archbold Medical Center to restrict the following uses and disclosures of my protected health information for treatment, payment, or health care operations:

_____

❑ Persons: I request Archbold Medical Center to restrict the following disclosures of my protected health information to the following persons assisting in my care (please describe specific disclosures, provide names of persons to whom this restriction would apply): _____

_____

❑ Other: _____

I understand, with some exceptions, that Archbold Medical Center is generally not required to agree to my request. Even if Archbold Medical Center agrees to my request, Archbold Medical Center may use or disclose my protected health information in emergencies, for its directory, and for certain other purposes permitted by the federal Privacy Rule.

_____ _____
Patient Signature Date/Time

For Health System Use Only:

❑ Patient's request reviewed to confirm all necessary information has been provided

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Patient was notified that information was needed; method of contact:
❑ Patient provided necessary information, and request is complete
❑ Patient did not provide necessary information; request remains incomplete

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Request reviewed by Director Health Information Management/Privacy Officer; Health System will not agree to restriction because: _____

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Request reviewed by Director Health Information Management/Privacy Officer; Health System will agree to restriction. The following Department(s) notified: _____

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Written notice of decision sent to patient

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Request Form and written notice to patient filed in patient's medical record.

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Patient terminates restriction
❑ In writing; written notification included in medical record
❑ Orally.

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Health System terminates restriction
❑ Patient contacted (means of contact: _____), orally agreed to termination
❑ Patient could not be reached or would not agree to termination.

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ Written notification of termination sent to patient, included in medical record

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____

❑ The following Departments notified of termination of agreement, effective date (if patient did not agree):

_____

Signature of Staff Person: _____ Date/Time: _____
Print Name and Title: _____