

Request for Limitations

I request that my protected health information not be disclosed to _____

(name of person) or for the following purposes: _____ (identify treatment, payment or health care operation purpose.)

I understand that the Student Health Service is not required to grant this request. Please provide your decision regarding this request to me by phone: _____

or by mail: _____

_____.

Patient Name: _____

ID#: P00 _____

Signature _____

Date: _____

To be completed by Privacy Officer

Request granted or denied (circle one.)

Patient notified by phone or by mailing copy of form (circle one.)

If the request is granted, a copy of this form goes into the patient chart, and the Privacy Officer maintains a copy for at least six years.

Signature of Privacy Officer _____

Date: _____

