SALUS

RESTRICTION REQUEST

Purpose: This form is to be used for an individual's request to restrict the use or disclosure of your protected health information.

SECTION A: Individual requesting restriction.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Policy Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your protected health information. We are under no obligation to agree to your request. We will respond to your request for restriction in writing. If Salus/HAS agrees to your request for restriction, in whole or in part, we will not use or disclose your protected health information. We may, notwithstanding our agreement, use or disclose the restricted protected health information in case of a medical emergency, or when required or authorized by law.

You or Salus may end a restriction agreement at any time by notifying the other in writing. If you agree with our decision to end the agreement, your information will no longer be subject to the restriction. If Salus/HAS unilaterally terminates the restriction, such termination will apply to information created or received after Salus/HAS furnishes its notice terminating the agreement. Salus does not send PHI to your health plan if you have paid for the services in full without using the health plan card.

SECTION B: Restriction requested.

Please specify the information, the use or disclosure of which you want to restrict:

_____

_____

Please state the restriction you want to apply to that information:

_____

_____

INDIVIDUAL'S SIGNATURE. YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____