PROVIDENCE
Health & Services

PATIENT REQUEST FOR REVOKING AN AUTHORIZATION TO USE & DISCLOSE -OR-TO RESTRICT A DESIGNATED RECORD SET

The purpose of this form is to allow a patient/patient representative to request that Providence Health & Services (PH&S) restrict how their information is used/disclosed **- OR -** for patient/patient representative to revoke an authorization to use and disclose protected health information.

This form must be completely and legibly filled out and returned for processing to:

Health Information Management

P.O. Box 4950

Portland, OR 97208

Phone (855) 234-2491 Fax: (855) 234-2493

Restriction Requests:

Submitting a request for restricting health information does not guarantee that PH&S can or will accept the requested. A letter of acceptance or denial will be provided within ten (10) business days.

Restrictions may be terminated if:

- You request, or agree to, the termination in writing
- You orally agree to the termination and oral agreement is documented
- PH&S informs you that it is terminating its agreement. In this case, the termination is only effective for protected health information created or received AFTER you have been notified of the termination.

Revocation Requests:

Revocations of an authorization to use and disclose information will be processed the day of receipt. If you submit a revocation, the information described in the authorization to use and disclose may no longer be used for the purpose of the written authorization. The only exception is when PH&S has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

All requests, pertinent correspondence and/or appeals will become a part of your permanent medical record.

Revised Aug. 2017

PROVIDENCE
Health & Services

PATIENT REQUEST FOR REVOKING AN AUTHORIZATION TO USE & DISCLOSE -OR-TO RESTRICT A DESIGNATED RECORD SET

Patient's Name: _____ DOB: _____

Other Name(s) Used: _____

Address: _____ Phone: _____

☐ I would like Providence Health Services to **restrict** the use or disclosure of my protected health information in the following manner:

_____

☐ I would like to **revoke** the following authorization to use an disclose my information:

_____

I understand PH&S may deny my request for restriction. My information is not restricted until I have received written confirmation that PH&S has agreed to my request. If the restriction is agreed to PH&S will continue to disclose my information in the following situations:

- For continuation and coordination of my care.
- When the law requires the use or disclosure of restricted information.
- When I authorize you in writing to use or disclose restricted information.
- For health agency oversight activities.

I understand that revocations will be in effect upon the day it is received with the exception of action taken in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

Sign Here: _____ Date: _____

If personal representative signs this request on behalf of the patient, complete the

Print Name: _____

Description of personal representative's authority: _____

Relationship to Patient: ☐ Power of Attorney for Healthcare* ☐ Legal guardian*
☐ Parent ☐ Other

*Attach legal documentation if you are the legal guardian or Power of Attorney for Health care

For Internal Use Only
Date Received: _____ Initials _____ MRN _____
Sent to: _____ Date: _____

◯ Restriction Accepted. Corresponded with patient/representative on this date: _____

◯ Denied: Reason: _____

Revised Aug. 2017