

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:

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.



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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: _____