PATIENT REQUEST TO RESTRICT A DESIGNATED RECORD SET AND/OR REVOKE A PREVIOUSLY SIGNED AUTHORIZATION.

The purpose of this form is to allow a patient or their representative to request that Providence St. Joseph Health restrict how their information is used or disclosed, **OR** to allow the patient or their representative to revoke a previously-signed authorization to use and disclose protected health information.

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

Providence Health Information Management
P.O. Box 4950
Portland, OR 97208
Email: ROIHIMpatientrights@r1rcm.com
Fax: (503) 215-7663

Restriction Requests:
Submitting a request for restricting the use or disclosure of health information does not guarantee that Providence St. Joseph Health can or will accept the request. We will respond with a letter of acceptance or denial within (10) business days.

Restrictions may be terminated if:

- You request, or agree to, the termination in writing.
- You verbally agree to the termination and the verbal agreementis documented.
- Providence St. Joseph Health 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:
Revocation 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 ofthe written authorization. The only exception is when Providence St. Joseph Health 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: _____ Phone: _____

Full Address: _____

Fax: _____ Email: _____

☐ I would like Providence St. Joseph Health 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 and disclose my information:

_____

I understand Providence St. Joseph Health may deny my request for restriction. My information is not restricted until I have received written confirmation that Providence St. Joseph Health has agreed to my request. If the restriction is accepted, Providence St. Joseph Health may 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 in writing to use or disclose restricted information.
- For health agency oversight activities.

I understand that revocation will be in effect upon the day itis 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 ofthe pa tient:

Print Name: _____

Description of personal representative's authority: _____

Relationship to Patient: ☐ DPOA for Healthcare* ☐ Legal guardian*

☐ Parent ☐ Other: _____

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

For Internal Use Only

Date Received: _____ Initials _____ MRN _____

Sent to: _____ Date: _____

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

◯ Denied: Reason: _____