

PATIENT REQUEST TO RESTRICT A DESIGNATED RECORD SET, REVOKE A PREVIOUSLY SIGNED AUTHORIZATION, OR TO OPT OUT OF CARE EVERYWHERE

The purpose of this form is to allow a patient or their representative to request that Providence Health & Services (PH&S) 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 St. Joseph's Hospital

Attn: Release of Information
500 E. Webster Ave.
Chewelah, WA 99109

ROI phone: 509-935-5236

ROI fax: 509-935-5233

Restriction Requests:

Submitting a request for restricting the use or disclosure of health information does not guarantee that PH&S can or will accept the request. We will respond with a letter of acceptance or denial within ten (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 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:

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 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: _____	Phone: _____
Full Address: _____	
Fax: _____	Email: _____

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 **opt out of Care Everywhere**.

I would like to **revoke** the following authorization to use and 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 accepted, PH&S 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 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:

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: _____