

Taylor Health and Wellness Center
Southwest Missouri State University
901 S. National Avenue, Springfield, MO 65804-0094
Phone: (417) 836-4000 Fax: (417) 836-4133 http://health.smsu.edu

RESTRICTION REQUEST FORM
FOR PROTECTED HEALTH INFORMATION

Instructions: Sections 1-3 must be completed. Please print all information except for signatures.

Section 1: **PATIENT IDENTIFICATION** Print Name: _____
Street Address, City, State & Zip Code: _____
Patient's Social Security Number: _____ Date of Birth: _____

Section 2: **RIGHT TO REQUEST RESTRICTION**

I understand I have the right to request a restriction of how Taylor Health and Wellness Center uses and discloses my protected health information. I understand that Taylor Health and Wellness Center will make every reasonable effort to agree to the restriction(s) requested regarding my protected health information.

Pursuant to that right, I hereby request Taylor Health and Wellness Center to make every reasonable effort to restrict use and disclosure of my protected health information as follows:

Section 3: **RIGHT OF DENIAL**

I understand Taylor Health and Wellness Center has the right to deny my request for a restriction on the use and disclosure of my protected health information to the extent allowed by law. I also understand that Taylor Health and Wellness Center may deny my request for restriction of my protected health information if it is not in writing or does not include a reason to support the request.

Signature of Patient Date
(If under 18 years of age-Parent, Legal Guardian, or Legal Representative)

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1: _____

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Section 4: **RESPONSE TO REQUEST** Date Received: _____ Initials: _____

Restriction has been: GRANTED DENIED with Right for Review
 DENIED with **no** Right for Review

If denied, please explain reason for denial: _____

Other Comments: _____

Signature of Privacy Officer Date

A copy of this form will be filed in the above-named patient's PHI.