

**REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF  
HEALTH INFORMATION**

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Address:  
(Street/Box) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Telephone: (day) (\_\_\_\_\_) \_\_\_\_\_ (eve) (\_\_\_\_\_) \_\_\_\_\_

Medical Record #: \_\_\_\_\_ (Optional)      Date Of Birth \_\_\_\_\_

Describe the restriction you are requesting for uses and disclosures made by Saint Joseph Mercy Health System: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Information on Your Rights to Request a Restriction**

You have the right to ask us to restrict how Saint Joseph Mercy Health System uses and discloses your health information for purposes of treatment, payment or health care operations (See Notice of Privacy Practices for more information on these types of uses and disclosures).

We are not required to agree to your request. ***If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment.*** If we do not agree to your request we will notify you of our decision in writing.

If a special restriction is agreed to, you have the right to terminate the restriction if:

- ◆ You request the termination in writing.
- ◆ You orally agree to the termination and your oral agreement is documented.

Saint Joseph Mercy Health System has the right to terminate a restriction if it informs you of the termination. In this case, the termination is only effective for health information created or received by Saint Joseph Mercy Health System after you are notified of the termination.

By submitting this form, I hereby request Saint Joseph Mercy Health System to restrict uses and disclosures of my health information as described above. I understand that Saint Joseph Mercy Health System is not required to agree to my request.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date form received

**This request should be sent to:** Saint Joseph Mercy Health System, Health Information Services, 5301 East Huron River Dr., PO Box 995, Ann Arbor, MI 48106-0995.

**Saint Joseph Mercy Health System’s Response to Your Request**

- We have reviewed your request for Saint Joseph Mercy Health System to restrict its uses and disclosures of your health information and have determined that Saint Joseph Mercy Health System will grant:
  - your entire request,
  - part of your requestAccordingly, we agree to restrict our uses and disclosures of your health information as follows:

\_\_\_\_\_

\_\_\_\_\_

- Saint Joseph Mercy Health System has reviewed your request for a restriction of our uses and disclosures of your health information and has determined that it must deny your request.

The following is information as to the basis for our denial:

\_\_\_\_\_

\_\_\_\_\_

**Request for Termination of Restriction**

The Individual named above requested a restriction on the use or disclosure of protected health information on \_\_\_\_\_.

Date

- The Individual requests that the special restriction be terminated.

Signature of patient or representative: \_\_\_\_\_

If representative, state relationship: \_\_\_\_\_ Date: \_\_\_\_\_

- The Individual agrees to the termination of the special restriction.

Signature of patient or representative: \_\_\_\_\_

If representative, state relationship: \_\_\_\_\_ Date: \_\_\_\_\_

- The Individual verbally agreed to the termination.

Signature of hospital representative who witnessed the verbal agreement: \_\_\_\_\_

Date: \_\_\_\_\_

- Saint Joseph Mercy Health System is hereby informing you that the restriction is terminated. This termination is effective only with respect to PHI created or received by us after you have received this notification.

Signature of hospital representative: \_\_\_\_\_ Date: \_\_\_\_\_