Jefferson County Department of Health

Request for Restriction of Use and Disclosure of Protected Health Information

Patient Information

Last Name	First name	Middle Name	Date of Birth
Address			Telephone Number
Medical Record Number (if known)		Date of Request	

I request the following restrictions on the use and/or disclosure of my protected health information for treatment, payment, or healthcare operations. To restrict disclosures to your health plan you must pay for services out of pocket in full at the time of service.

I request the following restrictions on the use or disclosure of my protected health information to a family member, other relative, or other identified person, directly relevant to this person's involvement with the individual's care or payment for health care. Please include name, address, and contact information of each person.

I understand I have the right to request restriction(s) as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations, or disclosed to family members and others involved in my care. I understand that JCDH is not required to agree to the restriction(s)requested. If denied, I will generally have an opportunity to agree or object prior to disclosures made to persons involved in my care. If JCDH agrees it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, JCDH will request the provider not to further use and/or disclose that information.

Patient/Legal Guardian/Patient Representative Signature* Relationship to Patient Date

*You may be required to submit evidence of guardianship or patient representative.

If your request is denied, you may submit a written statement of disagreement to Privacy Officer, Jefferson County Department of Health, 1400 6th Avenue South, Birmingham, AL 35233 or email www.hipaaprivacyofficer@jcdh.org.

Office Use (JCDH staff fax form to (205) 930-1305 or deliver to ROI Division)

Request Received By:_____(signature) Dept:_____Date:_____

Review Date:_____

Determination:

☐ Restriction Accepted ☐ Restriction Denied ☐ Restriction Accepted in Part Date Restrictions Begin_____

If denied or partially accepted, reason: _____

_____

Patient Notification Method_____Date_____(attach communication)

Approval Signature:_____ Date:_____

Original on File in ROI Division

JCDH-CSD-1232-12/2023

Jefferson County Department of Health

Revocation of Restriction of Use and Disclosure of Protected Health Information

Patient Information

Last Name	First name	Middle Name	Date of Birth
Address			Telephone Number
Medical Record Number (if known)		Date of Request	

Please read the following and complete the information requested:

☐ I revoke my previous request for restrictions of use and disclosure of my protected health information.

I understand that this revocation will not affect actions taken in accordance with my original request to restrict the use and disclosure of protected health information prior to the receipt of this written revocation. I also understand thay when my restrictions of use and disclosure of protected health information indicator is removed, the restrictions previously requested will no loner be honored.

I have read the above statements and attest that I no longer require the restriction to my health information.

Patient/Legal Guardian/Patient Representative Signature* Relationship to Patient Date

If revoked by Legal Guardian or Personal Representative, please print name:_____

*You may be required to submit evidence of guardianship or patient representative.

Office Use (JCDH staff fax form to (205) 930-1305 or deliver to ROI Division)

Request Received By:_____(signature) Dept:_____Date:_____

Review Date:_____

Date Restriction Removed:_____

Patient Notification Method_____Date_____(attach communication)

Signature:_____ Date:_____

Original on File in ROI Division
JCDH-CSD-1232-12/2023