CENTRAL OHIO PRIMARY CARE

REQUEST TO RESTRICT PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: _____ **Date of Birth:** _____
Last First Middle (M/D/Y)

Address: _____
Street City State Zip

Date of Request: _____ **Physician:** _____ **Practice:** _____

Telephone Number Where You Can Be Reached: _____

I understand that I have the right to restrict how COPC uses and discloses my PHI except for those uses and disclosures that are required by law. I also understand that COPC has the right to deny my request to restrict PHI and that I will be notified, in writing, of the denial decision.

☐ **Restrict the information from my service/item on _____ to my health plan because I have paid out of pocket and in full for this service/item.**

☐ **Restrict the following information:** _____

Restrict access to the following:

_____ _____
Name Address City State Zip

_____ _____
Name Address City State Zip

Effective Date of This Restriction: _____ **Date Restriction is To End:** _____
(M/D/Y) (M/D/Y)

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Patient's Legal Representative Relationship to Patient Date

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

_____

For COPC Use Only – forward to COPC Compliance Officer

Date Request Received: _____ **Restriction Was:** ☐ Accepted ☐ Denied

If denied, check reason(s) for denial:

☐ The Request for Restriction Form was not complete. You may complete the missing information highlighted above and resubmit your request to: COPC Compliance Officer, 655 Africa Road, Westerville, Ohio 43082

☐ The item/service was not paid for out of pocket and in full.

☐ The PHI cannot be restricted as required by law.

Comments: _____

Patient Notified By: ☐ Regular Mail ☐ Courier ☐ Certified Mail **Date Sent:** _____

_____ _____ _____ _____
Signature of COPC Authorized Representative (Name/Title) Date Signature of Health Care Provider (if applicable) Date

Form Revision: 9/23/2013