

Patient Name: MRN: DOB:

\* 100118\*

## Request for Restriction on Uses & Disclosures of Protected Health Information

Ple	ease complete the following informa	ation:	Date:				
1.	Date(s) of Encounter to be held as	Restricted:					
2.	Type of Encounter(s) to be held as Restricted:						
3.	Listing of Ancillary Service(s) to be held as Restricted:						
4.	From whom should this information be restricted:						
	Clinical (Lab) Test: Medical Imaging (x-ray)Test Behavioral Health Reports Therapy reports Other	List Specific Tests/Encounters	 	List the Date of the Tests			
5.	Name of the Healthcare Provider	(s) who was seen at the time o	of the Enc	ounter:			



Patient Name: MRN: DOB:

## Request for Restriction on Uses & Disclosures of Protected Health Information

## To be completed by Nemours

Restriction has been: Accepted Denied (If denied, check the reason for denial) Upon recommendation of the Health care Provider Upon recommendation of the Operational Review Team Federal/State law prohibits the restriction								
Comments by the Healthcare Pro	ovider:	Comments by the Operational Review Team			<b>:</b> -			
Request for Restriction has been	reviewed by the fo	llowing:						
Signature	Please Print Name	Date		Time	AM PM			
	Please Print Name	Date		Time	AM PM			
Notification was sent to:	Who received	l notice	Date Sent					
Patient/Legal Representative Provider Scheduling Central Billing Office (CBO) Medical Imaging Clinical Lab Other								
Signature of Staff Member		Please Print Name						
Please Print Title		 Date	Time	AM PM				

and all entities operating under the name

 $<sup>*</sup>Nemours\ includes:\ The\ Nemours\ Foundation, a\ Florida\ not-for-profit\ corporation, its\ operating\ divisions\ and\ sites, and\ its\ affiliates\ and\ subsidiaries, including\ Nemours$