Request Restriction or Termination on Use and Disclosure of Protected Health Information (PHI)

Patient Name:_____
Last First MI Maiden or Other Name

Date of Birth:____-_____-_____ Medical Record #:_____ Phone: _____

Address:_____City:_____ST: ____Zip:_____

Facility Visited: _____

- We are not required to agree to this restriction request, unless it is restricting disclosure of your PHI to a health plan or carrier for treatment or services for which **you have paid in full**. We may remove the restriction if your payment is not honored.
- We may voluntarily agree to other requests for restrictions. Any restrictions to which we have voluntarily agreed may be terminated by informing you of the termination.
- This restriction will not apply to any disclosures of PHI which occurred prior to implementation of this request.
- Restrictions will not apply when the restricted information is needed for emergency treatment.
- **Restrictions cannot apply to workers' compensation**.
- You may request termination of a previous restriction at any time.

I am requesting that Concentra: ❑ Place a restriction ❑ Remove a previous restriction on the use or disclosure of my protected health information:

Restricted Information: _____

Date of Service: _____

❑ Individual/Entity to whom PHI should not be disclosed: _____

❑ Other: _____

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT

You may submit this form:

- In person: to the nearest Concentra medical center
- By mail: Concentra Privacy Office
  5080 Spectrum DR, Ste 1200 W
  Addison, TX 75001
  ATTN: Privacy Office
- By fax: 214-775-4408
- By email: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY
Complete the sections below and
email this request to PrivacyOffice@Concentra.com or fax to 214-775-4408

Notice of Decision

❑ We have accepted the restriction(s) you have requested above.
❑ We have accepted only the following portion of the restriction(s) you have requested above:
_____
❑ We are unable to accept the restriction(s) you have requested above.
❑ We are informing you that the above restrictions are being terminated._____
Date
❑ Termination of restriction you have request has been completed._____
Date

_____ _____ _____ _____
Signature of Authorized Colleague Title Date Phone

_____ _____ _____ _____
Signature of Staff Member Title Date Phone

_____ _____
Facility Name Location Number (if applicable)