Patient Name: _____
Address: _____
Phone: _____
Date of Birth: _____ Sex: _____
Date of Service: _____
McLaren Facility and/or Provider: _____
Medical Record Number: _____

REQUEST FOR RESTRICTION ON THE USE AND DISCLOSURE OF HEALTH INFORMATION

You are requesting that McLaren Health Care restrict its use and/or disclosure of certain types of your protected health information as described below. This request only applies to McLaren Health Care. You will also need to contact your physicians, laboratories, pharmacies and other providers to request restrictions from them.

Please be aware that McLaren **is not required to grant your request for restrictions.** For example, McLaren may refuse any request for a restriction that could interfere with your care. If McLaren agrees to your request, McLaren will abide by the agreement, except when you require emergency treatment.

McLaren has the right to terminate a restriction if it informs you of the termination. In such a case, the termination is only effective for health information created or received by McLaren after you are notified of the termination.

Note that federal regulations permit you to request that McLaren restrict the sharing of protected health information with your health insurance provider for the purposes of payment or health care operations when you have paid in full for your health care.

By submitting this form, you are requesting that McLaren restrict uses and/or disclosures of my health information as described above. You understand that McLaren is **not required to agree to your request**.

Please describe the information you with to restrict. Please provide specific details and dates if applicable.

_____

_____

Signature of Patient/Legal Representative: _____ Date/Time: _____
Printed Patient Name: _____

MCLAREN HEALTH CARE PRIVACY OFFICER
One McLaren Parkway, Grand Blanc, MI 48439; or
Privacy@McLaren.org

MHC_CC1108.7.6

FOR MCLAREN HEALTH CARE USE ONLY:

Request status: □ Accepted □ Denied
Reason for denial, if applicable: _____
Date, Time and Method for Notification to Requestor: _____
Name and Title of Compliance Department Staff: _____
Signature of Compliance Department Staff: _____ **Date:** _____