Health
AUGUSTA UNIVERSITY

Complete and return this form to:
AU Medical Center
Medical Records BPM-210
1120 Fifteenth Street
Augusta, GA 30912

Request to Restrict Uses and Disclosures of Protected Health Information

Patient Name:		Patient MRN:
Date of Birth:	Phone:	Last four digits of Social Security Number:
Patient Address:		

You have the right to request additional restrictions on the way our health system uses and discloses your protected health information for treatment, payment or health care operations. You may also request limitations on how we disclose information about you to family or friends involved in your care. We are not required to agree to your request and in some cases the restriction you request may not be permitted under law. If we do agree, we will be bound by our agreement unless the information is needed to provide emergency care. You may terminate a restriction orally or in writing. We may terminate a restriction without your agreement; however, the termination will only apply to PHI created or received after you have been informed of the termination.

Fees: No fee will be charged for accommodating this request. However, we reserve the right to deny all or portions of each request if determined to be of an unreasonable nature, or to assess fees for certain requests that require on-going attention or excessive maintenance.

Restriction Requested:

☐ I have paid in full for _____ procedure or service provided on
_____ date(s) and I request a restriction of disclosure of this procedure or service to my health plan.

Describe the information you would like restricted. Include specific dates and treatments if possible. You may attach a separate page if more space is needed:

_____

_____

Limitations Requested: Describe how you would like the use of your protected health information limited, include any limitations you would like on how it may be disclosed to others:

_____

_____

_____

Conditions: I understand that by signing below, I am requesting the health system apply the above restriction and/or limitations in the way it uses and disclosed my protected health information.

_____

Signature of Patient or Legal Representative Date

** FOR AU MEDICAL CENTER USE ONLY **

Date Received: *Restriction has been:* ☐ *Accepted* ☐ *Denied* *Date Notified:* _____

Reason for Denial: _____

Accepting/Denying Authority: *Title/Department:*

Signature: *Date:*

PRIVRSTR