Date: ___________________

SSM HOME CARE

STREET ADDRESS: _______________________________________

CITY, STATE, ZIP: _______________________________________

RE: REQUEST FOR GENERAL RESTRICTION ON USE OR DISCLOSURE OF PHI (NOT INVOLVING A HEALTH PLAN)

Patient Printed Name: ____

Patient Social Security #: ____

I understand that SSM Health Care may use and disclose Protected Health Information without my consent for purposes of treatment, payment and health care operations. I request SSM Health Care to restrict certain uses and/or disclosures of my Protected Health Information as outlined below in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that SSM Health Care is not required to agree to this requested restriction.

Termination of Restriction

I understand that if SSM Health Care agrees to this restriction, either SSM Health Care or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that this restriction is void if Protected Health Information must be used or disclosed to provide emergency treatment for me.

Specifications: Please complete all of the following. If not applicable, mark N/A on the answer line.

(1) I request the following information be restricted [description of information]:

____

____

(2) I request that use and disclosure of the above-described information be restricted in the following manner [description of restriction]:

____

____

(3) I request that my Protected Health Information not be disclosed to the following individuals or entities:

____

____

(4) I understand that no restrictions except those specified above and agreed to in writing by SSM Health Care will be effective.

Patient Signature: __________________________________ Date: _____________

Address: ____

____

Phone Number: ______________________________

(5) If you are not the individual who is the subject of this Protected Health Information, you may request a restriction only if you are the "personal representative" of the individual as that term is described in the HIPAA Privacy Rules and/or determined under __________________ law. To assist us in determining whether you are a personal representative, please fill in the following:

Your printed name ____

Relationship to the individual:

___ Parent of the individual, who is under the age of 18.

___ Other. (Attach written evidence of authority.)

Signature: ____ Date: _____________

Address: ____

____

Phone Number: ______________________________

For Office Use Only:

- ❑ We have accepted the restriction you have requested above. This restriction will be continued until you request a termination of the restriction or until we terminate our agreement to the restriction, as permitted by law.
- ❑ We have denied the restriction that you have requested above.
- ❑ We are informing you that the above restriction is being terminated effective: __________________.
- ❑ Signature of Authorized Representative: ___________________________

DATE____________ TITLE__________________