v01.2023

Philadelphia FIGHT Community Health Centers

REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF MEDICAL INFORMATION

You are being asked to complete this form because you have asked for a restriction on the way FIGHT uses or discloses your medical information.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information FIGHT uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information FIGHT discloses about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that FIGHT not use or disclose information about a particular treatment you received.

FIGHT is not required to agree to your request and FIGHT may not be able to comply with your request. The exception to this rule is if you request that FIGHT restrict disclosures to a health plan if: (1) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law, and (2) the protected health information pertains only to a health care item or service which you or someone on your behalf other than the health plan, has paid FIGHT in full. If FIGHT does agree to the requested restriction, FIGHT will comply with your request except that FIGHT shall not comply, with the request if the law requires FIGHT to make a disclosure.

To request restrictions, you must make your request in writing. Please complete the following information:

Patient Name:_____ Date of Birth_____

What information do you want to limit?_____

_____

Describe how you want to restrict information (you may select both options):

☐ I am requesting to restrict FIGHT's Use of information
- Describe the Use/s of Information that you are requesting be restricted:

_____

_____

☐ I am requesting to restrict FIGHT's Disclosure of information to others listed below
- List person/s or entities that you are requesting be restricted from Disclosures:

_____

_____

This Request was made by:_____

Printed Name of Requestor- Patient or Legally Authorized Representative

_____ _____

Signature of patient or patient's Legally Authorized Representative Date

(Form MUST be completed before signing.)

Printed name of Patient's Legally Authorized Representative: Description of Legal Authority to act for the Patient:

_____ _____

FOR INTERNAL FIGHT USE ONLY

Staff must email this request form to FIGHT's Privacy Officer at privacy@fight.org, within ten (10) days of receipt of request.

This form can be submitted in person at any Philadelphia FIGHT Health Center, via email to privacy@fight.org, via fax 215-732-1145 Attention: Privacy Officer, or via mail Philadelphia FIGHT Privacy Officer, 1233 Locust St. 5th Floor, Philadelphia PA 19107.