REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to request a restriction of our use and disclosure of your protected health information (PHI) that we, or our business associates, maintain for treatment, payment or health care operations, to persons involved in your care, or payment for that care.

Please complete the following information:

Name			Birthdate
Address			
City	State	Zip Code	Daytime Phone Number

Please Read and complete the following information:

You have the right to request that we restrict our use and disclosure of your PHI for treatment, payment and healthcare operations to persons involved in your care, or payment for that care. We are not required to grant your request. If we do, our agreement will be in writing and we will restrict our use and disclosure of your PHI as you request. We may, however, use and disclose the restricted information in appropriate medical emergency situations, or when use or disclosure without your written permission is authorized or required by law.

You can terminate the restriction at any time by notifying us in writing. We can also terminate our agreement to a restriction at any time by notifying you in writing. If we do, termination is effective only to PHI that we create or receive *after* we give you our written notice terminating the restriction.

To exercise your right to request a restriction on our use and disclosure of your PHI, please specify the PHI you want to be handled in a restricted fashion, and the restrictions you want us to apply:

I request that Hill Country Medical Associates (HCMA) restrict the use and disclosure of my PHI as specified above. I understand that HCMA is not required to agree to my request. I also understand that if HCMA does agree to this request, you will inform me of any termination of the restriction in writing.

_____ _____

Signature Date

If you are making this request on behalf of a HCMA patient, please complete the information below and describe your relationship to the patient (example: Parent of a Minor Child, Legal Guardian, Power of Attorney, Executor, etc.). If you are not the parent of the patient, please attach proof of your relationship.

_____ _____

Printed Name of Representative Relationship

_____ _____

Signature Date