Oregon Health & Science University
Hospitals and Clinics
Information Privacy & Security Office
3181 SW Sam Jackson Park Rd
Mail Code: ITG 09
Portland, OR 97239-3098
(503) 494-0219, Fax (503) 494-4828

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

REQUEST FOR RESTRICTION ON USE & DISCLOSURE TO A HEALTH PLAN

SECTION A: Individual to complete the following information. (Please print)

NAME _____
Last First Middle

ADDRESS: _____

TELEPHONE NUMBER: _____ BIRTH DATE: _____

MEDICAL RECORD NUMBER: _____
(If applicable)

REQUEST:

I have paid out of pocket in full for the item/service and I hereby request that Oregon Health & Science University (OHSU) restrict the use & disclosure of health information to the following Health Plan (s):

_____

_____

Please specify the item or service subject to the requested restriction:

_____

_____

ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION

I understand that OHSU is required to agree to my requested restriction(s). The requested restriction only applies to release of information to a Health Plan for purposes of payment or health care operation, and only relates to health information for which I paid in full. The restriction is in effect (unless emergency or treatment circumstances require otherwise) until I agree to or request that the restriction be terminated.

Documentation about your request is maintained in the OHSU Integrated Health Record and can be obtained by calling Health Information Management (503) 494-1261 or the OHSU Information Privacy & Security Office (503) 494-0219.

Date: _____

Signature of Patient or Legal Representative: _____

Printed Name of Legal Representative (If applicable): _____

SECTION B: Please fax this form to Health Information Management at fax # 6-6816 for processing.

Staff comments: _____

_____

Signature of staff person: _____ Date: _____ Time: _____

Print name and title: _____

Department / Area: _____

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