Oregon Health & Science University
Hospitals and Clinics
Information Privacy & Security Office
3181 SW Sam Jackson Park Rd
Mail Code: ITG 05
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 OF HEALTH INFORMATION

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

NAME _____
Last First Middle

ADDRESS _____

TELEPHONE NO. _____ BIRTH DATE _____

+++
MEDICAL RECORD NO. _____
(If applicable)

REQUEST:

I hereby request that Oregon Health & Science University (OHSU) restrict the use & disclosure of health information in the following manner:

Please specify the type of health information and the requested restriction:

_____

_____

Please indicate the specific OHSU service area or department for which this applies: _____

ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION

I understand that OHSU does not have to agree to my requested restriction(s). If OHSU agrees to the requested restriction, then the restriction is in effect (unless emergency circumstances require otherwise) until one of the following events occurs:

- I agree to or request that the restriction be terminated; or
- OHSU notifies me in writing that they are terminating restriction in which case the termination is effective only as to information created or maintained after I am notified of the termination.

Documentation about an acceptance or denial of a request is maintained at the OHSU Information Privacy & Security Office and can be obtained by calling (503) 494-0219.

Date: _____

Signature of Patient or Legal Representative _____

Printed Name of Legal Representative (If applicable) _____

SECTION B: All requests shall be forwarded to the OHSU Privacy Officer or designee for review.

Request for restriction is: ☐ Accepted ☐ Denied

Staff comments _____

_____

Signature of staff person _____ Date _____ Time: _____

Print name and title _____

Department / Area _____

MR1449