Patient requests for restriction and termination of restrictions on use and disclosure of PHI.

Counseling and Life Management: CALM
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Counseling and Life Management: CALM 8752 122nd Ave NE Kirkland, WA 98033 206-300-2550

Patient request for restriction on use and disclosure of PHI

I request that **Ms. Doerflinger-Schneider** restricts the use and disclosure of protected health information (PHI) listed below. I understand that **Ms. Doerflinger-Schneider** may not agree to this request; provided, however, that **Ms. Doerflinger-Schneider** may be required by law to grant a restriction preventing disclosure to my health plan concerning services or items for which I have paid **Ms. Doerflinger-Schneider.**

Describe the restriction requested:

_____

_____

This restriction shall be in effect until (date or event):

_____

Patient Name, printed: _____

Signature: _____ Date: _____

Relationship if not patient:_____

Mailing Address for future correspondence regarding this restriction:

_____

Ms. Doerflinger-Schneider has reviewed the above request to restrict the use and disclosure of protected health information (PHI) and ***(check one)***

__ Denies the request as **Ms. Doerflinger-Schneider** cannot reasonably assure or guarantee the restriction can be met.

__ Accepts and will honor the request for the above stated restriction with the following exceptions and conditions:

- If you need emergency treatment and the restricted PHI is needed to provide emergency treatment, I may use the restricted PHI or may disclose this information to another health care provider to provide you with the emergency treatment.
- I will ask the health care provider to not further use or disclose the PHI.
- To the extent permitted by law, I may need to terminate or revoke our acceptance of this restriction. Of course, I will notify you of such unilateral termination.

Therapist's Signature: _____ Date: _____

Title: _____

Revoking or Terminating Restrictions of Use and Disclosure of Protected Health Information

Check One:

____ **Patient:** I hereby ***revoke*** the above restriction of the use and disclosure of my protected health information (PHI) effective _____ (date).

____ **Ms. Doerflinger-Schneider** previously agreed to the above restriction of the use and disclosure of your protected health information (PHI). To the extent permitted by law, **Ms. Doerflinger-Schneider** ***terminates this previous agreement*** and no longer will restrict the use and disclosure of your protected health information effective _____ (date).

Signed: _____ Date: _____

Printed Name: _____

Relationship if not patient: _____