



HEALTH CARE

REQUEST FOR RESTRICTION ON THE USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

Phone: _____

Date of Birth: _____ Sex: _____

Date of Service: _____

McLaren Facility and/or Provider: _____

Medical Record Number: _____

You are requesting that McLaren Health Care restrict its use and/or disclosure of certain types of your protected health information as described below. This request only applies to McLaren Health Care. You will also need to contact your physicians, laboratories, pharmacies and other providers to request restrictions from them.

Please be aware that McLaren **is not required to grant your request for restrictions**. For example, McLaren may refuse any request for a restriction that could interfere with your care. If McLaren agrees to your request, McLaren will abide by the agreement, except when you require emergency treatment.

McLaren has the right to terminate a restriction if it informs you of the termination. In such a case, the termination is only effective for health information created or received by McLaren after you are notified of the termination.

Note that federal regulations permit you to request that McLaren restrict the sharing of protected health information with your health insurance provider for the purposes of payment or health care operations when you have paid in full for your health care.

By submitting this form, you are requesting that McLaren restrict uses and/or disclosures of my health information as described above. You understand that McLaren is **not required to agree to your request**.

Please describe the information you wish to restrict. Please provide specific details and dates if applicable.

Signature of Patient/Legal Representative: _____ Date/Time: _____

Printed Patient Name: _____

McLAREN HEALTH CARE PRIVACY OFFICER

One McLaren Parkway, Grand Blanc, MI 48439

Privacy@McLaren.org

FOR McLAREN HEALTH CARE USE ONLY:

Request status: ☐ Accepted ☐ Denied

Reason for denial, if applicable: _____

Date, Time and Method for Notification to Requester: _____

Name and Title of Compliance Department Staff: _____

Signature of Compliance Department Staff: _____ Date: _____

