

HUNTINGTON MEDICAL FOUNDATION

REQUEST FOR SPECIAL PRIVACY PROTECTIONS

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person you identify who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates the agreement.

I hereby request special privacy protection for:

Patient's name: _____

Address _____

I do not want my health information be disclosed to any of the following people:

Name(s)	Address(es)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I do not want my health information used or disclosed for any of the following purposes:

This request replaces and terminates any prior request for special privacy protection I may have made.

Signed: _____

Date: _____

Signed: _____ Date: ___/___/___

Print Name _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____

NOTE: By law, this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions or workers' compensation activities.

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For office use only:

Date Granted: ___/___/___

Date Terminated: ___/___/___

Practice Amendments shown: Yes No