Restriction of Protected Health Information (PHI) Request Form

Contact Person: HIPAA Privacy Officer, HNI (as an Affiliated Covered Entity)

Contact Phone, Email and Fax: phone - (512) 730-3060 ext. 281, email - compliance@hnihc.com, fax - (737) 273-8520

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to this restriction, but if we do, we are bound by our agreement. Any restriction we accept will not apply when the restricted information is needed to provide you with emergency treatment. We further have the right to terminate any agreed upon restriction by informing you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.***

Please complete this form to request a restriction and we will notify you of our ability to comply with your request by returning a copy of this form to you, no later than 30 days from its receipt. You also have the right to request us to terminate a restriction to the extent that such termination applies to information created or received after the date of termination.

Requested Restrictions (please provide specific details and dates):

_____

_____

_____

Print Patient Name: _____

Signature of Patient or Authorized Representative: _____

Print Authorized Representative Name: _____

Date: _____

Relationship to Patient: _____

For HNI Office Use Only:

Practice: ☐ **Accepts** ☐ **Denies**

Privacy Officer Signature: _____

Date: _____

Note: The HNI ACE must honor requests for restrictions of health information by the patient if (1) the disclosure will be to an insurance company for purposes of payment or health care operations, and (2) the patient has paid for the service out of pocket in full.