



Specialty Behavioral Health

PATIENT REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF PHI

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

Describe the restriction requested: _____

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

Printed Patient Name: _____ Signature: _____

Date: _____ Relationship if not patient: _____

Mailing Address for future correspondence regarding this restriction:

James Carter, Ph.D. has reviewed the above request to restrict the use and disclosure of protected health information (PHI) and (**check one**):

Denies the request as James Carter, Ph.D 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).

James Carter, Ph.D. previously agreed to the above restriction of the use and disclosure of your protected health information (PHI). To the extent permitted by law, James Carter, Ph.D. **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: _____