FAU
FLORIDA ATLANTIC UNIVERSITY

REQUEST TO RESTRICT USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION ("PHI") FORM

Please indicate below the restrictions you are requesting on the use and disclosure of your Protected Health Information ("PHI"). Please note, we do not have to honor any request other than a request not to send information to an insurer for a claim paid out of pocket. If we agree to the restriction, we are bound to follow it. If we deny the restriction, we will notify you of the denial. We reserve the right to terminate an agreed-to restriction if we feel that the termination is appropriate, and you have the right to terminate, in writing, any restriction by sending a termination notice to FAU.

Requested Restriction:

_____

_____

_____

_____

Print Name: _____

Signature: _____

Date: _____

If legal representative, relationship to patient: _____

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FOR FAU USE ONLY:

Restriction Accepted [ ], Denied [ ].

Signature: _____

Date: _____

- Place this form in the patient's record -