Patient Name: _____ Birthdate: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Tel #: _____ Work Tel #: _____ Social Security #: _____

You have the right to request that Evergreen Healthcare restrict the use or disclosure of your protected health information. Evergreen Healthcare will attempt to honor your request, although we are not legally obligated to do so in most instances. If we agree to your request, we will notify you in writing.

Even if we agree to your request, we may continue to use or disclose the restricted information in the following situations:

- In a medical emergency when the information is needed for your treatment;
- When you authorize us in writing to use or disclose the information; or
- When law requires the use or disclosure.

You may end the restriction at any time by notifying us in writing. We may end the restriction at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we receive after we gave you our notice terminating the restriction.

NOTE: Other Federal and State regulations already restrict the use or disclosure of information pertaining to mental health, HIV and other sexually transmitted diseases, and alcohol and drug treatment.

Please list the protected health information you would like to restrict: _____

_____

Please state the restriction you would like to apply: _____

_____

☐ **Do not disclose information to my health plan. I understand that I must pay out of pocket for the healthcare service(s) involved. If I do not pay in full within 30 days of receipt of the bill, Evergreen has my permission to bill my health plan.**

☐ **I do not wish to receive mailings from Evergreen regarding:** ☐**Fundraising** ☐**Evergreen Services**

I request that Evergreen Healthcare restrict the use or disclosure of my protected health information as specified above. Except for disclosures to my health plan, I understand that Evergreen Healthcare is under no obligation to agree to my request and that there will be no agreement unless Evergreen Healthcare informs me in writing that it agrees to my request.

Signature: _____ Date: _____

(if signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____

Relationship to Patient: ☐Parent ☐Legal Guardian* ☐Holder of a Medical Power of Attorney*

* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

EVERGREEN
HOSPITAL MEDICAL CENTER
Kirkland, WA 98034

REQUEST TO RESTRICT USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FORM ID ADM 539
Approved 02/10
Item ID 16498

APPLY PATIENT LABEL HERE

Original - Medical Record Copies - Privacy Officer, Patient

MR