Name: _____ Phone #: _____ Birthdate:_____

Address: _____ City: _____ State: _____Zip: _____

You have the right to request that EvergreenHealth restrict the use or disclosure of your protected health information. EvergreenHealth is not legally obligated to agree to your request in most instances. We will notify you of the denial or acceptance of your request in writing.

When we agree to your request, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

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.

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

_____

Please state to whom you would like this restriction to apply: _____

_____

I request that EvergreenHealth restrict the use or disclosure of my protected health information as specified above.

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

EvergreenHealth Kirkland, WA 98034

REQUEST TO RESTRICT USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FORM ID ADM 539

Approved 7/18

APPLY PATIENT LABEL HERE

MR