REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____Phone _____

Date of Birth:_____ Date:_____

I understand that FCC may use or disclose my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations. FCC may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend. I understand that FCC does not have to agree to my request.

I hereby request a restriction on FCC's use or disclosure of protected health information. The information I want limited is:

_____
_____
_____

I want the limits to apply to the following person/entity:
_____

I understand that FCC does not have to agree to my request. Even if FCC agrees to the restriction, it may share information anyway in the following circumstances:

- During a medical emergency, if the restricted information is needed to provide emergency care.
- For certain public health activities
- For reporting abuse, neglect, domestic violence or other crimes
- For health oversight activities, law enforcement investigations, judicial or administrative proceedings
- For identifying decedents to the coroner, or determining a cause of death
- For worker's compensation programs
- For uses or disclosures otherwise required by law

If a special restriction is agreed to, it may be terminated if:

1. I request, or agree to, the termination in writing.

2. I orally agree to the termination and the oral agreement is documented.
3. FCC informs me that it is terminating our agreement. In this case, the termination is only effective for PHI created by FCC or received by FCC after I am notified of the termination.

_____

Signature of patient or representative Date

Relationship to patient (if representative:_____

When you have completed this form, please return it to the designated FCC Clinic Front Office
We will respond to your request within 30 days of receipt

Date received at FCC Front Office: _____