Request to Restrict Uses and Disclosures of Health Information

SECTION A: Individual completes the following information.

Date: ______________________________________ **Phone Number:** _____________

Name: _____________________________________ **Date of Birth:** _______________

Address: ____

REQUEST

I hereby request The Arc of Anchorage to restrict the use and disclosure of the following information **(check all that apply)**:

- ☐ Restrict uses and disclosure of health information for purposes of treatment, payment, or health care operations.
- ☐ Restrict disclosures to a family member, relative, or close personal friend that are involved with my health care. Please specify individual(s) to whom this restriction applies: ____
- ☐ Restrict disclosures to a family member, personal representative, or other person involved in my care for purposes of location, general condition, or death.

INDIVIDUAL ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION (individual to initial each condition)

______ I understand that The Arc of Anchorage is not required to agree to this request for restriction.

______ I understand that The Arc of Anchorage may agree to only a part of the request for restriction, while denying agreement to the remaining request.

______ I understand that, if The Arc of Anchorage agrees to the requested restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:

a. I agree to or request in writing that the restriction be terminated; or
b. The Arc of Anchorage notifies me in writing that they are terminating the agreement to restrict. If The Arc of Anchorage terminates the agreement to restrict, then the termination is effective only with respect to information created or maintained after the date of the restriction.

______ I understand that my restricted health information may be disclosed to provide emergency treatment and that The Arc of Anchorage will not further use or disclose my restricted health information for any other purpose.

______ I understand that I will have a right to access my health information as allowed under applicable law.

______ I understand that I may receive an accounting of disclosures as explained in The Arc of Anchorage Notice of Privacy Practices.

______ I understand that I still must inform The Arc of Anchorage if I do not want my name on the facility directory.

______ I understand that my restricted health information may still be disclosed for public policy purposes as stated in the Notice of Privacy Practices.

Printed Name of Individual

Individual's Signature | Date

Printed Name of Legal Representative/Guardian | Relationship to Individual

Legal Representative/Guardian's Signature | Date

SECTION B: The Arc of Anchorage completes the following information.

Request for restriction is:

☐ Accepted ☐ Denied

Comments: ____________________

Printed Name of Staff Member | Job Title

Staff Member's Signature | Date