



**Request to Restrict Use and/or Disclosure of  
an Individual's Protected Health Information  
Health Insurance Portability and Accountability Act of 1996  
45 CFR 160 §164.522**

Hill Physicians Member Name: \_\_\_\_\_

Hill Physicians MR Number: \_\_\_\_\_

I, \_\_\_\_\_, request that Hill Physicians Medical Group, Inc. ("Hill Physicians") and any of its business associates who have, will have or may have had access to my protected health information, as contained within the Hill Physicians designated record set, restrict the current or future use and/or disclosure of my protected health information as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that Hill Physicians is not required to agree to this requested restriction and that any denial of this restriction will be communicated to me in accordance with Hill Physicians' policies and procedures.

I understand that if Hill Physicians accepts the above restriction request, the restriction may be terminated in the following manner:

1. By Hill Physicians, its business associate, or my written request and my written acceptance of the termination; or
2. By Hill Physicians or its business associate's oral request and my oral acceptance of the request along with written documentation of the conversation; or
3. By written notification from Hill Physicians or its business associate that the restriction is being terminated only for PHI created after the notice date.

Dated: \_\_\_\_\_

By: \_\_\_\_\_

Signature

\_\_\_\_\_  
Print your name



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Hill Physicians Member Name:

\_\_\_\_\_

I am the authorized representative of \_\_\_\_\_. I am making this  
restriction request for and on behalf of the above individual for the following reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dated: \_\_\_\_\_

By: \_\_\_\_\_

Signature

\_\_\_\_\_  
Print your name

\_\_\_\_\_  
Your Title