Hill Physicians
Your health. It's our mission.

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