Request to Restrict Use or Disclosure of Your Health Info

To request that Hill Physicians Medical Group, and any of its business associates, who has, 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, please complete and submit the request form.

Is this request for yourself? (Required)

☐ Yes, this request is for myself ☐ No, this request is on behalf of someone

Individual's First and Last Name: (Required)

Prefix _____ First _____ Last _____

Specify the relationship with the individual: (Required) _____

I am making this restriction request for and on behalf of the above Individual for the following reason:

_____

_____

_____

Individual's Health Plan Member Number: (Required)

_____

I request that Hill Physicians Medical Group, and any of its business associates, who has, 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: (Required)

_____

_____

_____

Consent: (Required)

☐ **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.**

— Continued on back

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

1. By Hill Physicians', or their business associate's, or my written request and acceptance of the termination; or

2. By Hill Physicians', or their business associate's, oral request and my oral acceptance of the request along with written documentation of the conversation; or

3. Upon notification from Hill Physicians, or their business associate, that the restriction agreement is being terminated; however, such termination is only effective for protected health information created on or after the date on which I received notice of the restriction termination.

Signature: (Required)_____ Print Name_____

Your Title: (Required)_____ Dated: (Required)_____

Please return this form to Hill Physicians by mail or fax:

Mail

Hill Physicians Medical Group
Attn: Customer Service
P.O. Box 5080
San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Customer Service

